

Section III

Standards

**PROVIDER MANUAL
FOR
COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS
UNDER CONTRACT WITH
THE DIVISION OF MENTAL HEALTH,
Developmental Disabilities and
ADDICTIVE DISEASES**



JULY 2005

**Division
MHDDAD**

POLICY

No. 9.100
Effective Date:
April 30, 1998
Review Month:
February
Revision Effective:
July 1, 2003

SUBJECT: Provider Requirements for Accreditation and Certification

REFERENCE: Official Code of Georgia Annotated 37-2, 37-3, 37-4 and 37-7

I. POLICY STATEMENT

It is the policy of the Division of Mental Health, Developmental Disabilities and Addictive Diseases that providers contracting with the DHR through the division and its regional offices, or receiving funding through authorization from the division, in an amount **less than \$250,000** per year, must be certified by the Division of Mental Health Developmental Disabilities and Addictive Diseases. Providers receiving **\$250,000 or more** per year must be accredited by an approved accrediting body.

II. APPLICABILITY

This policy is applicable to the State and Regional Offices of the Division of MHDDAD.

III. DEFINITIONS

- A. Accreditation** - A review process conducted by a nationally recognized and approved accrediting body of a person or agency that is a direct service provider for people with mental illness, developmental disabilities or addictive diseases, focusing on prescribed standards as they relate to services and supports for those individuals.
- B. Waiver of Accreditation** - A letter stating that a person or agency may have an extension of a period of time during which to complete their accreditation process.
- C. Certification** - A review process conducted by the Certification Unit of the Division of Mental Health, Developmental Disabilities and Addictive Diseases of a person or agency that is a direct service provider for people with mental illness, developmental disabilities or addictive diseases, focusing on standards found in the "Core Requirements for All Providers."
- D. Waiver of Certification** - A letter stating that a person or agency may have an extension of a period of time during which to complete their certification process.
- E. Core Requirements for All Providers** - Core standards or requirements of the Division of MHDDAD that are applicable to all individual and organizational providers who receive funds authorized by the division through contract, sub-contract or letter of agreement, regardless of the accreditation or certification status of the provider.
- F. Approved Accrediting Bodies** - National accrediting organizations approved and recognized by the Division of Mental Health, Developmental Disabilities and Addictive Diseases are the following:
 - 1. CARF – the Rehabilitation Accreditation Commission
 - 2. JCAHO – The Joint Commission on Accreditation of Healthcare Organizations
 - 3. The Council – The Council on Quality and Leadership
 - 4. COA – Council on Accreditation of Services for Families and Children

- G. Funding through Authorization** - Cumulative monies received by providers including

any combination of funds through contract(s) or letter(s) of agreement with the department through the division:

1. State Dollars
2. Medicaid Waiver Funds
3. Medicaid Reimbursed Mental Health and Substance Abuse Services

H. License or Certificate - Proof of legal authority to operate. Examples of agencies that are required to be licensed or certified to provide direct care to consumers are (but are not limited to) the following:

1. Personal Care Homes
2. Private Home Care Providers
3. Freestanding Residential Detoxification Services
4. Nursing Homes
5. Crisis Stabilization Programs
6. Community Living Arrangements

IV. PROCEDURES

The department, through the division requires that all providers meet certain criteria which ensures their administrative capacity to do business with the division and their structure to provide necessary services and supports for individuals with MHDDAD disabilities.

A. Prior to entering into a contractual relationship with a provider of consumer services, the department, through DMHDDAD Regional Offices ensures that all persons or agencies with whom there is a contract or a "Letter of Agreement" are either accredited or certified and are licensed (if licensure is applicable) or that the person or agency is in preparation for accreditation, certification or licensure. The provider must submit to the regional office:

1. Proof of accreditation or certification including a report of outstanding deficiencies, if under a corrective action plan, or
2. Proof of application for accreditation or certification.
 - a. Persons or agencies whose operating history is not yet of sufficient length to be accredited must show proof of application for accreditation before the end of the first six months of their initial contract.
 - b. Persons or agencies whose operating history is not yet of sufficient length to be certified must show proof of application for certification before the end of the first six months of their initial contract.

Providers Under Accreditation:

B. Providers under contract with the DHR through the Division of MHDDAD for whom accreditation is required, must maintain full accreditation of all their services.

1. Failure to be fully accredited or to be in good standing with the accrediting body, may result in action being taken by the division:
 - a. The Regional Coordinator for the division may request a waiver of accreditation for a provider for a period of time not to exceed six (6) months, during which time the provider is expected to seek and successfully achieve accreditation. Waivers of accreditation are requested from the Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases by the Regional Coordinator.
 - b. Proof of application for accreditation must accompany the request for waiver.
 - c. The division may elect to take actions against the provider for failure to achieve or maintain accreditation while it is considering a waiver of accreditation.

- d. The division may elect to terminate the contract with the provider.
- C. The division will show preference for contracts with new providers who are currently accredited. If the department, through the division, elects to contract with a new provider who is not accredited and accreditation is required, the new provider must be fully accredited within twelve (12) months of the beginning of their contract. Until such time as the provider is accredited, all provisions found in Section IV,H, of this policy shall apply.
- D. If an accredited provider should lose accreditation, fail to reapply for accreditation or come under a corrective action plan, that provider must immediately notify in writing, the division through its regional office. The following actions shall apply:
- 1. Loss of accreditation: Loss of accreditation may result in termination of contract or letter of agreement.
 - 2. Failure to reapply: Failure to reapply will result in actions being taken against the provider. The provider will be given three (3) months during which they must make application to the accrediting agency and must submit written proof of application to the division's regional office prior to the end of the 3rd month.
 - 3. Providers under corrective action: Provider(s) must immediately notify the division's regional office when corrective action is required and provide a copy of the accrediting agency's correspondence regarding the corrective action. The provider(s) under a corrective action plan(s) must successfully correct their deficiencies and provide a copy of the corrective action plan(s) to the division's regional office at the time the corrective action plan(s) is/are submitted to the accrediting agency. A copy of response(s) from the accrediting agency must be provided to the division's regional office immediately upon receipt of the response(s).

Providers Under Certification:

- E. Providers under contract with the department for provision of MHDDAD services, for whom certification is required, must be certified and must subsequently maintain certification of all of their services.
- 1. The Certification Unit of the division conducts the initial reviews for certification of the providers.
 - 2. The Regional Coordinator for the division is notified that the review for certification is scheduled and the results of that review. The certification process is conducted as follows:
 - a. Notice is given to the provider with a copy to the division's regional office of the date for the certification review.
 - b. Pursuant to the certification review, within thirty (30) days of the date of the report of review, the provider must state in writing their intent to make corrective action(s), if applicable.
 - c. The provider must submit initial evidence of corrective action(s) to the Evaluation and Certification Unit of the division within sixty (60) days of the date of the report of review.
 - d. After 120 days of the date of the report of review, an unannounced visit will be made by the Evaluation and Certification Unit to the provider to review corrective action(s) taken.
 - 3. If a provider does not meet the "Core Requirements for All Providers," at the end of the corrective action period, action may be taken by the Regional Coordinator for the Division of MHDDAD.

- a. The Regional Coordinator for the division may request a waiver of certification for a period of time not to exceed ninety (90) days during which time the provider shall have a final opportunity to correct remaining issues that are out of compliance. Waivers of certification are requested from the Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases, by the Regional Coordinator for the division. The Regional Coordinator for the division may choose to take action against the provider during this time.
 - 1) At the end of the ninety (90) days, the Certification Unit will review those issues that were out of compliance.
 - 2) Pursuant to the review by the Certification Unit after the ninety (90) day period, the agency or provider must be found fully in compliance or the division will terminate the department's contract with the provider.
 - b. The division may elect to terminate the department's contract with the provider.
4. All providers achieving certification are certified for two (2) years, after which time certification expires and a new certification is required.
- F.** Providers whose contract or LOA is terminated due to failure to be certified may not make application for certification for at least six (6) calendar months following the date of their last certification review. Such application for certification may only be made if the provider is under a new contract or LOA with the department to provide MHDDAD services.
- G.** The division will show preference for new providers who are currently certified. If the department, through the division elects to contract with a new provider who is not certified and certification is required, the new provider must be fully certified within 12 months of the beginning of their contract. Until such time as the certification process is implemented by the Certification Unit, all provisions found in Section IV, H, of this policy shall apply.

All Providers:

- H.** During the period of time before a provider becomes accredited or certified, oversight activities shall be conducted by staff from the regional office of the Division of MHDDAD in the following way:
1. A visit shall occur at 90 days from the date of the contract or letter or agreement. The visit shall include a review of:
 - a. Environmental safety
 - b. Interpersonal care
 - c. Social activities
 - d. Habilitation activities
 - e. Evidence of choice
 - f. Evidence of satisfaction
 - g. Evidence of personal safety
 2. A visit shall occur 180 days from the date of the contract or letter of agreement. The visit shall include a review of:
 - a. CQI plan and evidence of implementation
 - b. Emergency policies and corresponding practices
 - c. Serious and Unusual Incidents policy and practice
 - d. Clients rights practices
 - e. Grievance processes

- f. Medications management policy and procedures
- g. Confidentiality policy and practice
- h. Personnel files, focusing on evidence of current staff training
- i. Physical health care practices
- j. Documentation of service delivery
- k. Client financial documentation, including how fees or charges are assessed

Oversight activities shall be alternately repeated every ninety (90) days until the provider is accredited or certified or the individual or agency is no longer a provider of direct consumer services.

- I. The Regional Coordinator for the division may ask staff from the state office of the Division of Mental Health, Developmental Disabilities and Addictive Diseases to conduct a special review of any provider as circumstances warrant.

**Section/Office/Unit Responsible for Policy
Development/Review**
Consumer Protection, CQI and Monitoring Section

Approved by:
Karl Schwarzkopf, Director
October 21, 2003

CORE REQUIREMENTS FOR ALL PROVIDERS

FY06 Provider Manual Standards

There are minimal changes to the standards. Requirements for working with persons with challenging behaviors are now clarified. The manual, *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*, is incorporated into the *FY06 Provider Manual Standards* by reference. Several values are clarified. Diagnostic Assessment and the role of MHCs is also clarified.

I. SYSTEM VALUES

A. RECOVERY AND SELF-DETERMINATION

Consumers and families have choices about MHDDAD services through:

- participation in designing the MHDDAD service system;
- full participation in development of their service plan;
- selection of service providers, location of services and other factors related to implementation of the service plan; and
- opportunity for and development of self-determination and the capacity to make choices in every day life.

B. Valued Role

Consumers are supported to participate in the everyday life of their community, with their family, friends and natural/community support system. Inclusion and the reduction of stigma are valued. Children and adolescents are supported to remain in their own homes with their families.

Consumers are served in the most inclusive, most participative environment possible that meets the needs of the individual served while encouraging the greatest amount of independence possible.

D. Quality of Services

Consumers have the highest quality services provided by a competent staff, utilizing flexibility and incentives that reinforce quality and efficiency. Where there are known practices which show efficacy, these technologies should be accessible to the consumers.

E. Individualized Services and Supports

Persons served are provided services and supports at the appropriate level of intensity based on their individual strengths, needs and preferences with sensitivity to cultural difference, age appropriateness and gender specific needs.

II. ORGANIZATION PROFESSIONAL PRACTICES

A. General Management

- PP.1** The organization that enters into contracts, subcontracts or agreements with other agencies remains responsible for the affiliate's compliance with: 1) Accreditation principles and specified requirements of the provider manual; 2) Financial oversight and management; 3) Demonstration of an organized, confidential system of information management.
- PP.2** The organization operates in accordance with applicable statutory requirements, rules, regulations, contractual and sub-contractual requirements, policies, and procedures. There is documentation to support these activities.
- PP.3** The organization's administrative and clinical leaders design and promote identifiable administrative structures, relationships, and responsibilities.
- PP.4** The organization has clearly stated, promulgated, and current policies and procedures for all aspects of its operation.
- PP.5** The organization has a current defined purpose and plan that describes the needs and preferences of current and potential consumers and customers and how the organization plans to strategically address these needs.
- PP.6** The organization promotes practices that assist individuals in pursuing interests, preferences and needs through community integration and inclusion.
- PP.7** The organization details the desired expectations of the support services offered and the outcomes for each of these services.
- PP.8** The organization makes known its role, functions, and capacities to other organizations as appropriate to its array of service as a basis for joint planning efforts, continuity in cooperative service delivery, provider networking, referrals, contracts and sub-contracts. *When these communications are specific to an individual person served, this is documented in that person's record of service.*
- PP.9** The organization promotes practices which do not discriminate and which promote individuals with the same problems and needs receiving equitable supports from the organization.
- PP. 10** The organization has policies and procedures related to grievances and appeals that may be sought by persons served, staff of the organization and other appropriate parties.
- PP.11** The organization, which wants to conduct research involving consumers, shall develop a design which is approved by the agency's governing authority, the Regional Coordinator for the Division of MHDDAD, and is submitted and reviewed by the Department of Human Resources Institutional Review Board.

- PP.12** The research design shall include a statement of rationale, a plan to disclose benefits and risks of research to the participating person, a commitment to obtain written consent of the person participating, and a plan to acquire documentation that the person is informed that they can withdraw from the research process at any time.
- PP.13** If applicable, the organization has policies and procedures that govern the use of unusual medications and investigational and experimental drugs. *This process is considered a research design and, as such, follows all guidelines set by these standards. In addition the design is approved and supervised by a physician; information on the drugs is maintained including drug dosage forms, dosage range, storage requirements, adverse reactions, usage and contraindications; pharmacological training about the drug is provided to nurses who administer the medications, and the drugs are properly labeled.*
- PP.14** The organization has policies and clear accountability practices for the safeguarding, management and consumer use of consumer valuables or consumer finances. Organizational policies address the event in which the organization (by virtue of clinical assessment and/or agreement with the person served or their designated representative if available) has to assume responsibility for the safeguarding or management of consumer valuables or finances. The organization shall demonstrate special care to assure that consumer funds are not mismanaged or exploited. Procedures define the checks and balances established to ensure agency accountability. The agency is able to demonstrate evidence of working toward the goal of participative management of the personal funds of the consumer. Personal consumer funds are readily accessible for consumer use. A mechanism is in place, at least on a quarterly basis, to assure that the consumer is aware of monies that are in their personal account. A statement of funds received and spent is provided to the consumer when requested. Consumer monies shall not be co-mingled with agency or other consumer monies.
- PP.15** When the person served is unable to manage funds and there is no other person in the life of the consumer who is willing and able to assist in the management of consumer valuables or finances, the organization is able to demonstrate an ongoing effort to secure an independent party to manage those valuables or finances.
- PP.16** The organization offers access to services or supports without regards to age, gender, religion, and social status, physical or mental handicap for otherwise eligible persons. There is no geographical, architectural, communication, attitudinal, or procedural barriers in accessing the supports of the organization. The organization demonstrates sensitivity to differences represented by persons served.
- PP.17** The organization conducts or participates in activities that promote inclusion and the reduction of stigma for the persons supported.
- PP.18** The organization has policies, practices and outcomes that demonstrate input and involvement from persons served, families, advocates, and business and community representatives.
- PP.19** The organization may not exempt itself from one or any of these standards or provider manual. Individual standards and provider manual requirements may be requested to be waived by written request from the Regional Coordinator for the

B. Information Management

- IM.1** The organization has policies and practices related to consumer records and the transfer of information from records of persons served that demonstrates evidence of secure and confidential information management, which complies with applicable federal and state laws (including HIPAA Privacy Rules, 45 CFR Parts 160 and 164) and which allows it to be accountable to internal and external information stakeholders. Policies and procedures must address processes related to confidentiality, billing and all service related information that is generated by the information management system. Specific special requirements for Substance Abuse services include:
- 1) Confidentiality procedures for substance abuse consumer records comply with 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule (June 9, 1987), or subsequent revisions thereof. All substance abuse consumers are provided written notice about the confidentiality of substance abuse records at the time of admission or soon thereafter when the consumer is capable of rational communication. This notification is documented in the consumer's record. The consumer's signature on the notification form shall serve as documentation of notification.*
 - 2) Each disclosure or release of information made with the consumer's written consent is accompanied by a "Statement of Prohibition on Re-disclosure" as noted in 42 CFR, Part 2, Section 2.32.*
- IM.2** The organization obtains authorization for release of information when information is to be released or shared between organizations or with others outside the treating agency. The signed authorization for release of information form must include: 1) Specific information to be released or obtained; 2) The time period that this authorization remains in effect; 3) A statement that authorization may be revoked at any time by the consumer in advance of the exchange of information; 4) For what purpose it is to be given; and 5) To whom it is to be given.
- IM.3** The organization has written operational procedures, consistent with legal requirements governing the retention, maintenance, purging and destruction of records. Records are safely secured, maintained, and retained for a minimum of six (6) years from the date of its creation or the date when last in effect (whichever is later).
- IM.4** The organization maintains a current, comprehensive record for every individual assessed, treated, served or supported which includes such essential information as is deemed necessary in order to provide supports, protect the organization or comply with legal regulation. The record shall communicate information in a manner that is organized, clear, complete, and current.
- IM.5** All entries in the consumer record are dated and authenticated with their authors identified.

- IM.6** The record contains information to identify the individual, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care. These items include, at minimum: *1) Consumer identification information; 2) Identification of a person to contact in the event of emergency; 3) Basic screening and intake information; 4) Documentation of internal or external referrals; 5) Comprehensive diagnostic and psychosocial assessments; 6) Pertinent medical information; 7) Plans and goals for the person served; 8) Support services provided; 9) Progress information; 10) Discharge information and planning; 11) Appropriate consent for services; 12) Appropriate release of information forms; and 13) Specific allergies (or no known allergies) displayed both on the front of the consumer record binder, documented with the pertinent medical information, and documented prominently on the medication administration record (if the consumer receives medication); and 14) photocopies of legal documentation establishing incompetence, guardianship, etc.*
- IM.7** All entries in the clinical record are written in black or blue ink. Errors must be corrected by lining through, but not obliterating, the error, labeling the change with the word “error,” and initialing and dating the correction. Write-overs or correction fluid may not be used to correct entries.
- IM.8** The organization justifies any individual exceptions to record-keeping standards in that specific record.
- IM.9** When the person supported is being provided intensive services (for example, residential supports, 24-hour crisis stabilization, assertive community treatment, or partial hospitalization), documentation shall be written that reflects the clinical events and progress of the person served, the organization has policies which address this practice specific to the intensity of services and supports provided through its mission.

C. Professional Designations

1. Mental Health Professional (MHP): The following are considered to be Mental Health Professionals:

- a. **Psychiatrist-** A physician licensed to practice medicine or osteopathy in Georgia, who has completed a residency in psychiatry approved by the American Board of Psychiatry and Neurology.
- b. **Physician-** A person who is licensed to practice medicine or osteopathy in Georgia and with specialized training or one year of experience in treating persons with mental illness.
- c. **Physician’s Assistant** – A skilled person qualified by academic and practical training to provide patients’ services not necessarily within the physical presence but under the personal direction or supervision of a physician and who has one-year experience in treating persons with mental illness.
- d. **Advanced Practice Nurse -** Practice by a registered professional nurse who meets those educational, practice, certification requirements, or any combination of such requirements, as specified by the Georgia Board of Nursing and includes certified nurse midwives, nurse practitioners, certified registered nurse

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anesthetists, clinical nurse specialists in psychiatric/mental health, and others
recognized by the board and who have one year experience in treating persons
with mental illness.

- e. **Registered Nurse (Bachelor Degree)** – A registered nurse who is authorized by a license to practice nursing as a registered professional nurse and who holds a bachelor's degree in nursing with one year experience in psychiatry or mental health
- f. **Registered Nurse (Associate Degree or Diploma)-** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing and who has three years of experience, two of which are in psychiatry or mental health.
- g. **Social Worker, Professional Counselor or Marriage and Family Therapist-** A social worker, professional counselor or marriage and family therapist licensed in Georgia, including individuals who hold an associate license in professional counseling or marriage and family therapy, with documentation of supervised clinical experience in field placements.
- h. **Clinical Chaplain-** A graduate of a school of theology who has completed at least one year (four quarters) of training as a clinical chaplain in a program accredited by the Association for Clinical Pastoral Education, American Association of Pastoral Counselors, or American Association of Mental Health Chaplains.
- i. **Psychologist-** A holder of a doctoral degree from an accredited university or college and who is licensed in the State of Georgia.
- j. **Master's or Doctoral Degree Holders-** In one of the behavioral or social sciences that is primarily psychological in nature, and documentation of supervised clinical experience in an internship or practicum placement program, or those licensed in Georgia to practice independently.
- k. **MHP Equivalent-** Individual who has been designated as a MHP based on training and experience equivalent to that of a MHP. No new MHP equivalencies will be granted, however those holding this status prior to July 1, 1999 may be allowed to continue to have the MHP designation. The MHP equivalent is agency dependent and is non-transferable. When an MHP equivalent individual leaves an agency, the individual may no longer retain this equivalency.

2. Developmental Disability Professional (DDP) The following are considered to be Developmental Disability Professionals:

- a. **Psychologist** - A holder of a doctoral degree from an accredited university or college and who is licensed in the State of Georgia and who has specialized training or one year of experience in mental retardation or developmental disabilities.

- b. **Physician-** A physician licensed under State law to practice medicine or osteopathy and with specialized training or one year of experience in treating persons with mental retardation or developmental disabilities.
- c. **Physician's Assistant** – A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervisions of a physician and who has one year experience in mental retardation or developmental disabilities.
- d. **Advanced Practice Nurse** - Practice by a registered professional nurse who meets those educational, practice, certification requirements, or any combination of such requirements, as specified by the Georgia Board of Nursing and includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, and others recognized by the board and who have one year experience in mental retardation or developmental disabilities.
- e. **Master's or Doctoral Degree Holders-** A person with a Masters or Doctoral degree in one of the behavioral or social sciences with specialized training or one year of experience in working with persons with mental retardation or developmental disabilities.
- f. **Educator-** An educator with a degree in education from an accredited program and with specialized training or one year of experience in working with persons with mental retardation or developmental disabilities.
- g. **Human Service Professional-** A human services professional with a bachelor's degree in social work or a bachelor's degree in human services field other than social work (including the study of human behavior, human development or basic human care needs) and with specialized training or one year of experience in working with persons with mental retardation or developmental disabilities.
- h. **Physical or Occupational Therapist-** A licensed physical or occupational therapist who has specialized training or one year of experience in treating persons with mental retardation or developmental disabilities.
- i. **Speech Pathologist or Audiologist-** A licensed speech pathologist or audiologist who has specialized training or one year of experience in treating persons with mental retardation or developmental disabilities.
- j. **Registered Nurse (Bachelor Degree)** – A registered nurse who is authorized by a license to practice nursing as a registered professional nurse and who holds a bachelor's degree in nursing with one year experience in mental retardation or developmental disabilities.
- k. **Registered Nurse (Associate Degree or Diploma)-** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing and who has three years of experience, two of which are in mental retardation or developmental disabilities.

1. **Therapeutic Recreation Specialist-** A therapeutic recreation specialist who graduate of an accredited program and who had specialized training or one year experience in working with persons with mental retardation or developmental disabilities.

3. Substance Abuse Manager (SAM) The following are considered to be Substance Abuse Managers:

- a. **Physician-** A physician licensed to practice medicine or osteopathy in Georgia, who has specialized training/certification in addiction or one year of experience treating persons with addictive diseases.
- b. **Psychologist-** A psychologist licensed in the State of Georgia with specialized training/certification in addiction or one year of experience treating persons with addictive diseases.
- c. **Social Worker, Professional Counselor or Marriage and Family Therapist-** A social worker, professional counselor or marriage and family therapist licensed in Georgia, including individuals who hold an associate license in professional counseling or marriage and family therapy, with specialized training/certification in addiction or one year of experience treating persons with addictive diseases.
- d. **Physician's Assistant –** A skilled person qualified by academic and practical training to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of a physician and who has specialized training or certification in addiction or one year experience in treating persons with addictive diseases.
- e. **Advanced Practice Nurse -** Practice by a registered professional nurse who meets those educational, practice, certification requirements, or any combination of such requirements, as specified by the Georgia Board of Nursing and includes certified nurse midwives, nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists in psychiatric/mental health, and others recognized by the board and who has specialized training or certification in addiction or one year of experience in treating persons with addictive diseases.
- f. **Registered Nurse (Bachelor Degree) –** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse and who holds a bachelor's degree in nursing with specialized training or certification in addiction or one year of experience in addictive diseases.
- g. **Registered Nurse (Associate Degree or Diploma)-** A registered nurse who is authorized by a license to practice nursing as a registered professional nurse, who holds an associate or diploma degree in nursing, who has specialized training or certification in addiction or who has three years of experience, two of which are in addictive diseases.

- h. **Bachelor's, Master's or Doctoral Degree Holders-** In one of the behavioral or social sciences that is primarily psychological in nature and certification as a Certified Addiction Counselor II by the Georgia Addiction Counselors Association, or certification by the National Association of Alcoholism and Drug Abuse Counselors, or certification by the International Credentialing Reciprocity Consortium as a Certified Alcohol and Drug Counselor. Individuals with certification as a Certified Addiction Counselor II or as a Certified Alcohol and Drug Counselor prior to January 1, 2000 are considered SAMs regardless of educational status.
- i. **Certified Employee Assistance Professional-** certified employee assistance professional with 18 months of full time substance abuse specific clinical experience in the treatment of persons with addictive diseases and documented ongoing continuing education in the field of substance abuse.

4. Substance Abuse Professional (SAP)

NOTE: Substance Abuse Professionals (SAP) must work under the supervision of a Substance Abuse Manager (SAM). Their clinical work must be reviewed and signed by the SAM supervisor. The following are considered to be Substance Abuse Professionals:

- a. Any individual designated as a **Substance Abuse Manager** also meets the requirements for designation as a Substance Abuse Professional.
- b. Individuals, regardless of professional education and training, who have certification by the Georgia Addiction Counselors Association as a Certified Addiction Counselor I.

5. Mental Health Clinician (MHC)

NOTE: Mental Health Clinicians must work under the supervision of a Mental Health Professional (MHP). Their clinical work must be reviewed and signed by the MHP supervisor. The following are considered to be Mental Health Clinicians:

- a. Bachelor Degree holders in one of the behavioral or social sciences, from an accredited university or college, that is primarily psychological in nature who have documentation of two (2) years supervised clinical/work experience in the field of mental health.
- b. Registered Nurse, licensed to practice in the State of Georgia who does not hold adequate experience or certification to be a MHP.
- c. Clinical Interns or Practicum Students in a Master's degree program in one of the behavioral or social sciences at an accredited university or college, that is primarily psychological in nature.

- d. Master's Degree holders in a behavioral or social science field that is primarily psychological in nature, from an accredited university or college. Documented experience is not a requirement.

D. Human Resources Development

- HR.1** The organization has policies and procedures that address human resources and staff development. *These include:*
 - a) *Processes for determining the qualifications (training, experience, and documented competence) required of staff persons;*
 - b) *Processes for managing personnel information/records including criminal background checks and driver's license check;*
 - c) *Plans for adequate staffing patterns as needed for provision of support services;*
 - d) *Provisions for the timely orientation of personnel, periodic assessments of training needs of personnel, and the development of activities/training which respond to these assessments and identified needs and an annual work performance evaluation for the employee;*
 - e) *Residential programs must maintain the same documentation and information on personnel as is required by the Office of Regulatory Services.*
- HR.2** The organization shall demonstrate administration of personnel policies without discrimination.
- HR.3** The organization shall have job descriptions for all personnel that include job qualifications, job duties and responsibilities, expectation regarding quality and quantity of work, and documentation that the description is provided to the individual personnel.
- HR.4** The organization provides professional services and supports through staff with applicable licensure, certification, and/or registration requirements for the assignment of duties. There is evidence of proper licensure and certification as required by professional practice acts.
- HR.5** The organization has procedures for verifying the credentials of all staff members and volunteers; granting clinical privileges based on these credentials, certification, or licensure as applicable to State law; and reviewing these credentials and competencies on a regular basis. *Personnel records should include documentation of current licenses and certification.*
- HR.6** The organization requires that criminal records check be completed for all employees who perform direct care, treatment and/or custodial services. There is a mandatory disqualification from employment in positions subject to criminal history record checks for a minimum of five (5) years from the date of conviction, plea of no lo contendere, or release from incarceration or probation, whichever is later, for the following crimes: a) *Murder or felony murder;* b) *Attempted murder;* c)

Kidnapping; d) Rape; e) Armed robbery; f) Cruelty to children; g) Sexual offenses; h) Aggravated assault; I) Aggravated battery; j) Arson; k) Theft by taking, by deception or by conversion; and l) Forgery in the first or second degree. The organization is prohibited from hiring into direct care or custody positions any person who has been convicted of child, client or patient abuse, neglect or mistreatment, regardless of the date, unless exception is recommended by the Regional Coordinator and approved by the Division Director of Regional Operations and the Division Director for MHDDAD. There is documentation of the criminal records check process and all findings. Refer to DHR Policy #504.

- HR.7** The organization has policies and practices which provide that certain services can only be performed by a Mental Health Professional (MHP), Mental Health Clinician (MHC), Developmental Disability Professional (DDP), Substance Abuse Manager (SAM), or Substance Abuse Professional (SAP), to consumer groups consistent with their area of expertise. Only a MHP, DDP, or SAM supervises the provision of counseling services. The following services are to be provided only by a MHP, MHC, DDP, SAM or SAP: *1) Formulate the Individual Service Plans for services to be delivered(an MHC may not do this specific service); 2) Provide crisis intervention screening and evaluation services; 3) Screen by telephone or face-to-face and when indicated, provide face-to-face evaluation and intervention; and 4) Participate as members of community crisis intervention teams.* A MHP, MHC, DDP, SAM or SAP must be included on each community crisis team. Note: Mental Health Clinicians (MHC) must work under the supervision of a Mental Health Professional (MHP). Substance Abuse Professionals (SAP) must work under the supervision of a Substance Abuse Manager (SAM). The clinical work of the MHC or SAP must be reviewed and signed by their respective supervisor.
- HR.8** The organization has policies and practices, which provide that all mental health services are provided by or under the direct supervision of a MHP, all mental retardation or developmental disabilities services are provided by or under the direct supervision of a DDP; all substance abuse services are provided by or under the direct supervision of a SAM. Individuals not qualifying as a MHP, DDP or SAM may provide other services, as specified in the professional designation section of these standards.
- HR.9** The organization has policies and practices that communicate a strong preference that persons employed to carry out MHP/MHC/DDP/SAM/SAP duties are licensed or credentialed in an appropriate behavioral health field. Evidence of professional competence and licensure are documented and maintained. 1) Current MHP /DDP/SAM/SAP's who are not licensed in their field of work may be allowed to continue to have the designation. 2) Unlicensed MHP/MHC/DDP/SAM/SAP's are required to obtain clinical supervision of their MHP/MHC/DDP/SAM/SAP work by a licensed professional in their field.
- HR.10** The organization shall provide orientation for direct care, support staff and volunteers. Prior to contact with consumers, each staff member and volunteer shall be trained and show evidence of competence in: 1) Rights and responsibilities of consumers; 2) Requirements that staff and volunteers recognize and immediately report suspected abuse, neglect, or exploitation of any consumer to the Division, appropriate regulatory agencies and to law enforcement agencies as required; and 3) Confidentiality. The orientation includes training on the purpose, scope of support services, and policies and procedures of the organization.

- HR.11** In addition to training identified by the organization, direct care staff receives training in the following specific areas 1) Person centered values and principles; 2) The medical, physical, behavioral, and social needs and characteristics of the persons served; 3) Promoting appropriate and responsive relationships with persons served and their families; 4) The prevention, support and management of challenging and unsafe behaviors through positive behavior supports, including techniques to de-escalate challenging and unsafe behaviors; 5) Nationally benchmarked techniques for safe use of permitted emergency intervention(s) of last resort; 6) Ethics and cultural competence and appropriateness; 7) Fire safety and emergency evacuation plans and procedures 8) Techniques of Standard Precautions; 9) Basic cardiac life support (CPR), first aid and safety; 10) Common and specific consumer medications and their side effects; 11) Disability and program-specific topics appropriate to the work of each staff member, such as symptom management, relapse prevention and principles of recovery.
- HR.12** Within the first sixty days and annually thereafter, staff and volunteers shall receive at least sixteen hours of training that enhances their ability to meet the needs of the person served and the organization.
- HR.13** The organization has policies, plans, and practices to evaluate and improve its cultural diversity competencies including attention to governance representation, human resources, assessment, treatment supports, and communications.
- HR.14** The organization has practices that ensure that at all times and on all occasions, universal precautions are practiced. Staff in positions at risk of exposure to HIV; receive periodic continuing education on preventative measures, current information, and approaches to consumer education.
- HR.15** The organization schedules for each setting at least one staff person currently BCLS certified and trained in first aid and safety to be on duty during all hours of support service provision.
- HR.16** Any individual found not to be competent to perform MHP/MHC/DDP/SAM/SAP duties is removed from performance of these duties until their competency can be certified by the clinical director of the agency or a licensed professional in the appropriate field.
- HR.17** The organization has policies and practices, which specify mechanisms for the regular review, evaluation, and supervision of each staff member. *The evaluation component of this process should occur annually and should be conducted by persons clinically qualified to assess the staff performance (E.g. a physician should evaluate a physician's work).*
- HR.18** Mental Health Professionals, Mental Health Clinicians, Developmental Disability Professionals, Substance Abuse Managers, and Substance Abuse Professionals have a documented annual review of their competence to perform these MHP, MHC, DDP, SAM and SAP functions.
- HR.19** The organization conducts the annual review and certifies the competence of the individual to continue to perform the functions of the MHP, MHC, DDP, SAM and SAP. The annual review and certification is completed and documented by a professional in the field appropriate to the function being performed.

E. Wellness, Routine Healthcare and Medical Management

- HM.1** The organization that provides medical or psychiatric services has access to a medical director, physician consultant, or psychiatric physician consultant (as appropriate) who advises and provides direction to the organization staff on medical matters. If the organization does not provide a particular consultant or service required by the person served, evidence of access to that consultant or service outside of the organization is required.
- HM.2** The organization has a written plan to ensure that physical examinations, laboratory tests, dental services and emergency medical care not directly provided by the organization can be obtained and that outcomes are reviewed for support implications as necessary. *This should include plans determined by the medical consultation as an adequate standard for the level of service and for access in individual circumstances based on need.*
- HM.3** The organization facilitates wellness of persons served through advocacy, consumer care practices, education and sensitivity to gender, cultural and age appropriate issues affecting wellness, and through acknowledgement of consumer preference by incorporating wellness goals into the ISP.
- HM.4** The organization is able to demonstrate individual and corporate advocacy and education efforts related to routine healthcare of persons served. Healthcare issues will be identified and addressed or access facilitated.
- HM.5** The organization has mechanisms to address emergent needs.
- HM.6** Organizations providing residential services shall also have evidence of routine preventative healthcare as well as healthcare targeted toward needs of persons served. All healthcare issues of persons served shall be identified and incorporated into the ISP. Interventions are consistent with standards of care.

F. Medication Administration and Management

- MM.1** The organization, as applicable to its support service array, has written procedures for prescribing, ordering or authenticating orders, procuring, dispensing, supervision of consumer self-administration of medications, recording, and for disposal of discontinued or out-of-date medications.
- MM.2** The organization has protocols governing documentation of when the medication was administered and who administered the medication, including documentation of self-administration of medications when applicable.
- MM.3** For each medication, the instruction for use, dosage and frequency, must be documented. Medication must be recorded each day and each time that it is given. Missed or refused medications must also be documented in the person's medication administration record.
- MM.4** The organization's policy and practices for medication management include immediate notification of the prescribing professional regarding drug reactions, medication problems, refusal of medication by the consumer, and medication errors.

- MM.5** The organization that administers medication or that supervises the self-administration of medications has policies, procedures, and controls governing proper administration, storage and monitoring as defined by law and best practice. These policies include stipulations that: *1) Only licensed medical personnel can directly administer medication; 2) Only physicians or pharmacists may re-package or dispense medications; 3) There are safeguards utilized for medications known to have substantial risk or undesirable effects; 4) Require the education of persons served and families regarding potential risks and expected benefits of medication; 5) Define protocols and training to support and promote consumer self-administration of medication; 6) Require the education of staff regarding medication use, monitoring, and supervision of consumer self-administration of medications; 7) Practices are in place for handling both illicit and licit drugs brought into the service support setting by persons served; and 8) The storage of medication is in secured areas as according to law.*
- MM.6** The organization, which allows verbal orders from physicians, has policies and practices, which determine those who are approved and authorized to give and receive these orders. *The prescribing physician within a policy-designated time frame authenticates verbal orders.*
- MM.7** The organization assures practices for the regular and ongoing physician review of prescribed medications including the appropriateness of and need for continued use of each medication and monitoring of the presence of side effects. *When consumers are on medications likely to cause tardive dyskinesia, an Abnormal Involuntary Movement Scale is used as a monitoring tool at selected intervals.*

III. QUALITY OF THE SERVICE ENVIRONMENT

- QE.1.** Children seventeen and younger may not be served with adults. Emancipated minors and juveniles who are age 17 years may be served with adults when their life circumstances demonstrate they are more appropriately served in an adult environment.
- QE.2** The organization provides services and supports to persons served in a clean and safe environment.
- QE.3** Each facility shall be in compliance with fire and safety rules promulgated by the Office of the Safety Fire Commissioner. Each facility shall comply and demonstrate annual compliance with any and all local ordinances that specifically address fire safety in facilities of that size and function. Private quarters shall be maintained in such a manner as to comply with Fire Safety codes and not threaten the health or safety of residents. Water and sewage systems shall meet applicable federal, state, and local standards and/or regulations. Copies of inspection must be kept on-site.
- QE.4** The organization contracting with the Division of MHDDAD and any subcontracted providers of the organization are prohibited from referring or placing a consumer in a home, facility or service that is not properly licensed or certified as required by the type of home, facility or service provided.
- QE.5** The organization has policies, written procedures and evidence of practice that reflect a program of at least semi-annual inspection and preventive maintenance in relation to safety, equipment use, environmental hazards, and cleanliness at all sites. The organization is able to produce documentation of the same.

- QE.6** The organization is responsible for providing and maintaining equipment and practice for fire detection and prevention, warning of fire hazards, and extinguishing fires in accordance with local or state fire codes.
- QE.7** The organization has policies, plans, and procedures that address emergency notification and preparedness. Components of plans are maintained, tested, inspected, drilled and reviewed for risk reduction on a regular basis. *These plans should at minimum address medical emergencies, natural disasters, power failures, continuity in critical medical care needs of persons supported, and notification of person's natural supports as soon as the situation renders this possible.* Emergency drills are conducted at least quarterly for each day, evening, and night shift of support services. Fire drills are conducted every month at alternating times and shifts, including two per year during sleeping hours.
- QE.8** The organization offers adequate lighting, ventilation and temperature control in supported settings.
- QE.9** The organization has sufficient space, equipment and privacy necessary to accommodate accessibility, safety, anticipated waiting times and to provide identified services and supports for persons served.
- QE.10** The organization promotes environments that are respectful of persons supported. *Examples of this include the promotion of these persons partnering in controlling environments (lighting, temperature, design, decoration, and rule/policy design) and the utilization of age appropriate environments.*
- QE.11** The organization, in its managed sites, has accessible a telephone for private conversation for use by persons supported.
- QE.12** The organization deemed as an intake/assessment unit or crisis unit promotes access by utilizing clearly labeled exterior signs and/or other means of direction to service and support delivery locations as appropriate.
- QE.13** The organization providing residential support options provides for integrated and inclusive environments within established residential neighborhoods or adheres to requirements of specific service definitions (Section VI of the standards). *Examples of this include the selection of residential support options in areas with the appearance of normal community homes and primarily populated by non-served persons, selection of sites of a type ordinarily considered to be one family units, space for informal gatherings, and privacy for the person supported.*
- QE.14** The organization has policies and practices for transportation of all persons served including those served by contract, subcontract or through Letter of Agreement. These policies and practices include written procedures for proper maintenance of vehicles, handling emergencies, necessary fire suppression equipment in vehicles, maintaining an up-to-date first aid kit in vehicles, authenticating licenses of drivers, training of drivers, maintaining proof of adequate insurance, and the utilization of appropriate passenger safety restraints (seat belts). Policies and procedures apply to all vehicles used for transport of persons served,

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including those owned or leased by the organization or its subcontractors, as
well
as personal staff vehicles used to transport persons in service.

IV. IMPROVING ORGANIZATION QUALITY

- QI.1** The organization has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving the quality of services and supports to persons served. This approach is documented in organizational policy and evidenced in practice. The organization establishes indicators of performance that are routinely measured and evaluated. The organization is able to demonstrate how information gathered is utilized to develop and implement solutions to identified issues, and to make improvements.
- QI.2** The process for assessing and improving the quality of services and supports includes reviews of service modalities or organizational practices that represent areas of risk to the organization (including staff, visitors and persons served) which include but are not limited to medication management, incidents and accidents, grievances and complaints, and practices that limit freedom of choice.
- QI.3** The organization reviews and compiles reports concerning the numbers of grievances and complaints, the categories of grievances and complaints and the analysis of trends to determine the need for systematic changes in service provision.
- QI.4** Incidents are reported to the Division of MHDDAD as required by Policy 2:101: *Reporting of Consumer Deaths and Critical Incidents*. Incidents, including consumer deaths are reviewed individually and analyzed over time to identify opportunities for improvements in service delivery.
- QI.5** The organization summarizes and disseminates, on a quarterly basis clear, accurate and timely information about its efforts for improving quality and reducing risk. This information should be distributed to persons served or their representatives, personnel, governing body, and other stakeholders, as determined by the governance authority.
- QI.6** The organization's governing authority and management demonstrate a commitment to supporting and maintaining these quality improvement and risk reduction processes.
- QI.7** The organization identifies the processes to be used for the review of service and support appropriateness, effectiveness, efficiency, and quality related to persons served. *These may include internal peer review, external professional review, consumer/family satisfaction surveys, documentation and tracking of consumer outcomes, and other reliable and valid tools for measurement of consumer progress and outcomes.* The organization has an outcome measurement system that incorporates input from persons served and other appropriate stakeholders.
- QI.8** The organization reviews five percent of consumer records per quarter to 1) Verify whether services are based on assessment and need; 2) Verify documentation of service delivery; 3) Verify documentation of health service delivery, including accurate delivery of medications; 4) Track medication issues; 5) Assure that challenging behaviors (if any) are addressed as specified in the *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*; 6) Verify

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that consumer choice is evident; and to 7) Determine that the record is organized, complete, accurate, timely, and useful as a tool in providing effective service. The review shall include a representative sample of high-risk cases.

- QI.9** There is evidence that issues identified by record reviews have been addressed and corrective action implemented.
- QI.10** The organization shall implement an infection control plan that addresses the prevention, identification and control of potential infections.
- QI.11** The process for assessing and improving overall performance includes mechanisms to insure appropriate utilization of fiscal and human resources.
- QI.12** The organization has a written budget that serves as a plan for managing resources.
- QI.13** The organization uses positive behavior supports systematically and in all situations when working with persons served throughout the organization. If the organization serves individuals with challenging or unsafe behaviors, the organization follows guidelines found in *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*. If crisis plans or safety plans are utilized, the organization assesses risk associated with the techniques used in a crisis or safety plan and reviews the frequency and appropriateness of technique(s) utilized through ISP reviews through risk management reviews and activities. Issues include, but may not be limited to: 1) Assuring that behavior support plans are written using ONLY positive behavior supports and that restrictive measures are not utilized; 2) Tracking the appropriateness and effectiveness of the positive behavior support plan(s) and corresponding interventions; 3) If utilized, assuring the appropriateness and effectiveness of crisis or safety plan(s); and 4) Assuring that PRN medications are used ONLY for targeted medical or psychiatric symptoms.
- QI.14** The organization that is authorized by law or regulation to utilize any type of safety interventions of last resort shall systematically assess risks associated with techniques utilized and shall review the frequency and appropriateness of the interventions used on an ongoing basis and at ISP/clinical care reviews. Issues include, but may not be limited to: 1) Appropriateness and effectiveness of early interventions; 2) Use of PRN medications for purposes other than for targeted medical or psychiatric symptoms; 3) Frequency and reason for use of mechanical restraints; 4) Frequency and reason for use of personal restraints; 5) Frequency and reason for use of seclusion; 6) Assurance that the organization follows *Rules of Department of Human Resources Mental Health, Mental Retardation and Substance Abuse, Chapter 290-4-6: Patients Rights* when implementing any type of safety intervention of last resort; 7) For adults, follows best practice procedures found at 42CFR482.13(f) related to the use of seclusion and restraint for management of challenging behaviors; and 8) for children and youth, follows best practice procedures found at in rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* in 42 CFR Part 483 Subpart G.
NOTE that if the community setting by virtue of services provided is subject to specific requirements for adults or children youth found in 42 CFR 482 or 483, the community setting is expected to comply as specified in the CFR.

- QI.15** The organization that handles medications or oversees the self-administration of medication by consumers shall review processes and problems with the administration, dispensing, prescription, and supervision of medications including consumer self-administration of medication as applicable to the scope of practice. Corrective actions and steps taken to improve procedures are documented and included as part of the organization's on-going quality improvement process.

V. RIGHT OF THE PERSONS SERVED

- RI.1** The organization treats all persons served with dignity and respect at all times.
- RI.2** The organization has written policies and practices which protect and delineate the rights of persons served in accordance with state and federal statutes.
- RI.3** The organization provides persons served with information about their rights at the onset of care and periodically throughout the support duration. Patient's Rights information should be posted on a bulletin board accessible to all consumers or be given to consumers in pamphlet form. *This information includes how the consumer may voice complaints or grievances, is provided in a manner the person/family can understand, and is documented.*
- RI.4** The organization provides to the person served any necessary orientation to the organization or to the supports offered. *This may include responsibilities in care/support, expected involvement in care/support and orientation and adherence to any applicable service support rules.*
- RI.5** The organization promotes the sharing of information with persons served, their families and other support network as applicable, which enables them to make an informed choice through self-determination. The organization follows Georgia law as it pertains to obtaining permission to discuss the care of the individual with others, including their families.
- RI.6** The organization's policies and procedures shall prohibit corporal punishment, fear-eliciting procedures, abuse or procedures that withhold nutritional care.

V. SERVICE AND SUPPORTS DELIVERY PROCESSES

- SS.1** The organization has screening and intake practices that are described in written policies and procedures and are congruent with Division of MHDDAD contractual stipulations. The organization has policies and procedures that allow designated staff to determine a person's eligibility in keeping with Division of MHDDAD contract stipulations and which allow a determination as to whether the organization can provide the supports and services needed by the person served.
- SS.2** The organization shall provide initial face-to-face assessment contact for non-emergency services within two weeks of request for service.
- SS.3** The organization has policies, procedures and practices indicating that access to any and all services and supports are based on the needs assessment of each individual person served.

- SS.4** The organization provides continuity of care and supports during the assessment, diagnosis, planning, treatment and discharge phases for the person served. *This must include a responsiveness to the abilities and preferences of the person served, participation by persons responsible to deliver the supports provided, necessary coordination with external and internal service providers, and communication of information inside and outside the organization as appropriate.*
- SS.5** The organization utilizes the findings of the assessment(s) as a foundation for developing skills and participative supports for the person served.
- SS.6** The organization provides basic services and supports to accommodate persons served during non-traditional business hours.
- SS.7** The organization is expected to obtain or perform a comprehensive assessment for each person served. *The assessment should include, at minimum, the following:*
- a) The consumer's strengths, needs, abilities and preferences;*
 - b) With consent from the person served, the family's perception of strengths, needs, abilities and preferences of the person being assessed;*
 - c) With consent from the person served, input from other resources who may be important to the person;*
 - d) Medical history;*
 - e) Current health history status report or examination in cases where medications or other health interventions may be needed to support the person served, where confounding health factors complicate assessment, where allergies or adverse reactions to medications have occurred, or where withdrawal from a substance is an issue;*
 - f) Any diagnostic tools, impairment indices, or laboratory tests;*
 - g) A summary of information which includes a diagnostic impression and identification of impairments;*
 - h) Social History;*
 - i) Family History; and*
 - j) Child and Adolescent School Records as appropriate.*
- SS.8** The organization is expected to perform or obtain additional assessments for persons served as related to the services it provides. If additional assessment needs are standard for all persons receiving services within the organization, they should be identified within organization policy. *These may include:*
- a) Emotional assessments;*
 - b) Behavioral assessments;*
 - c) Assessment of trauma or abuse;*
 - d) Independent living skills assessment;*
 - e) Social assessments;*
 - f) Recreational assessments;*
 - g) Educational assessments;*
 - h) Vocational assessments*
 - i) Developmental assessments*
 - j) Cognitive assessments;*
 - k) Nutritional assessments;*
 - l) Legal concerns review;*
 - m) Cultural assessments; and*

n) *Spiritual assessments*

- SS.9** The organization has written policies and practices for referral from one service element to another within the agency and to other agencies or providers. *These practices are based on individual's assessed needs and the expectation of the organization to provide or obtain needed supports.*
- SS.10** The organization documents when a person served does not present for a scheduled service. Follow-up about this event must be documented.
- SS.11** The organization completes progress notes that document the actual implementation of the planned supports at appropriate intervals, direct contacts with the person served or identified partners in support, other strategies or interventions which have impacted the identified goals, and the results of the supports offered in relation to the identified goals.
- SS.12** The organization has a process for ongoing communication between staff members working with the same consumer(s) on different schedules, shifts, activities or programs so to ensure program continuity and communication of vital consumer information not appropriate for the consumer record but critical to continuity of care of the person served.
- SS.13** An individualized service or program plan is written for each person served. Each plan reflects the following:
1. A statement of the goals or desired outcomes, based on the specific strengths, needs, abilities and preferences of the person served
 2. The kinds of services to be provided to obtain these goals and the frequency of services;
 3. Identification by signature of the collaborative effort of provider personnel planning the services, including appropriate medical or other professional involvement by a physician. At a minimum, the collaborative personnel should include:
 - a) MHP, DDP, SAP, or SAM
 - b) The representative of all direct provider(s) of services
 4. Documentation of the consumer's involvement and, if the consumer's capacity permits and the consumer's accordance with the individualized service or program plan.
 5. Evidence of review and update at least annually or as indicated by the changing needs, circumstances, and responses of the person supported or by consumer request.
 6. Evidence that the organization assists the person in the identification of goals that guides the individualized plan for participative supports and services for each person served. *The person supported has active participation in this design process and this participation is validated by documentation. The family, advocates, and other support resources should be included as determined by the person served or his/her representative.*
 7. Evidence of a responsiveness to the abilities and preferences of the person served, participation by persons responsible for the supports provided, necessary coordination with external and internal service providers, and communication of information inside and outside the organization as appropriate.

- SS.14** The individualized plan should relate directly to the identified goals of the person and should include the following:
- a) *Measurable and achievable objectives;*
 - b) *Supports and services to be offered by the organization to achieve those objectives;*
 - c) *Supports available to the person from other sources to achieve those objectives; and*
 - d) *Anticipated frequency and intensity of support delivery*
- SS.15** For those persons with coexisting, complex and confounding needs, cross-disciplinary approaches to planning should be used. *This planning should be facilitated by persons who are qualified to provide supports for persons with coexisting disabilities or impairments through the organization or through referral. When this planning includes medical support development, a physician authorizes the plan.*
- SS.16** The organization utilizes intensive special treatment procedures only as required by the needs of persons served. If intensive special treatment procedures are used, these special treatment procedures are based on the need of persons served, designed by professionals in the field utilizing an interdisciplinary approach, and incorporated in the ISP of the individual served. There are organizational policies and procedures surrounding the use of intensive special treatment procedures.
- SS.17** The organization must specify in their policies how consumers are supported in a positive and safe manner when consumers present challenging behaviors. When the organization utilizes positive behavior support plans or safety plans for consumers, the policies, procedures and practices of the organization must address behavior management as the promotion of positive, constructive and functional behaviors with strategies to minimize or eliminate challenging behaviors, which have been identified in consumer planning as detrimental or unacceptable. There must be evidence that the plan is 1) *Individualized*; 2) *Includes the rule out of medical or psychiatric issues*; 3) *Based on a functional assessment*; 4) *Developed, reviewed and monitored by interdisciplinary teams for appropriateness*; 5) *Implemented and overseen by competent, experienced and trained staff persons*; 6) *Discussed and planned with the person served and family, as permitted by the person served*; and 7) *Includes rationale for the use of the identified approaches, the scheduled timing of their use, an assessment of the impact on the self-determination of the person, the targeted challenging behavior and how it will be determined that satisfactory re-direction or elimination of the this targeted challenging behavior has been achieved*. Positive behavior support plans and safety plans shall be developed under the guidance of the appropriate MHP or DDP. A consumer's positive behavior support plan or safety plan shall be incorporated by reference as part of the consumer's Individualized Service Plan. Refer to *Guidelines for Supporting Adults with Challenging Behaviors in Community Settings*.
- a. **SS.18** The organization that is authorized by law or regulation to utilize any emergency safety intervention of last resort (including personal restraint, mechanical restraint, and seclusion) shall have the following in place: 1) *Policies, procedures and practices which a. identify techniques approved for use; b. specify the circumstances under which such use is permitted; c. specify contraindications for*

use; d. specify the method for systematic assessment of associated risks; e. address the preservation of consumer rights, dignity and respect;

2) Staff who is specifically trained in nationally benchmarked techniques to carry out emergency interventions of last resort;

3) Evidence of practice demonstrating use of less restrictive interventions and preservation of consumer rights, dignity and respect.

SS.19 The organization authorized by law or regulation to utilize emergency safety interventions of last resort shall be able to demonstrate policy and practice within the organization that addresses the following: *A) How the organization creates a culture which emphasizes the systematic use of positive behavioral supports; B) Prevention of escalating challenging behavior by using de-escalation techniques as alternatives to use of an emergency safety interventions of last resort; C) Emergency safety interventions of last resort are only administered by designated and qualified personnel who are trained in proper techniques of applying and monitoring the procedures; D) Education to the person served and/or family regarding the use of these techniques in advance, if the need has been identified, or the family is at least notified immediately after the incident occurs; E) Demand for documentation which supports that the least restrictive intervention techniques have been tried prior to the use of emergency safety interventions of last resort to prevent challenging behaviors which are harmful to the person served or others; F) Demand for documentation which includes the rationale for the use of the identified approaches, the date/time/duration of the incident, a summary of the delivery of the support, and relevant events that preceded and followed the incident; G) Face-to-face attention to the person's needs is given at least every fifteen minutes by a trained staff person and that this interaction is documented; H) Procedures never be utilized as punishment or for the convenience of staff in lieu of adequate programming or staff; and I) That the individualized planning and physician authorization for devices that may restrain movement, but are applied for the protection of accidental injury or are required for the medical treatment of the person supported. A plan for potential utilization of any emergency safety intervention of last resort is incorporated by reference as part of the consumer's Individualized Service Plan.*

SS.20 At the onset of the planning process for each person served, the organization shall plan for a decrease in intensity of supports as goals that are projected to be achieved.

SS.21 The organization completes a discharge summary for each person served who is leaving the support of the program. The summary must include the strengths, needs, preferences and abilities of the person served, the services provided, the expectation achieved through support services, and any necessary plans for referral. *The discharge summary is completed within 30 working days of support termination and a copy is provided to the person served.*

SS.22 The program description identifies staff to consumer ratios for various service components. Ratios reflect the needs of consumers served and best practice guidelines.

SS.23 Crisis Stabilization Programs (CSP) providing medically monitored short-term residential psychiatric stabilization and detoxification services, shall be designated

SS.24 the Office of Regulatory Services must license the organization offering only
residential detoxification services.

VI. SERVICE DESCRIPTIONS

The service descriptions contained in the document are to serve as the basis for a common understanding of the services that the Division of MHDDAD purchases. The Regional Coordinator may modify the services described in this document via a contract or letter of agreement for the Division of MHDDAD.

Regional Coordinators are free to require providers to meet additional or more stringent standards or service descriptions in order to more effectively meet the needs of the region. If a service description needs clarification or is unclear, the region's interpretation should be sought. Services may be provided in differing levels of intensity based on consumer need.

The service descriptions are broken into a description of the service, the target population for the service and the expected benefit the consumer is to receive from the provision of the service. As always, the target population for all treatment, rehabilitative and habilitative services are the most in need population. The definition for most in need is:

1. Disability

The individual demonstrates:

- a) Challenging behavior leading to public demand for intervention; or
- b) Substantial risk of harm to self or others; or
- c) Substantial inability to demonstrate community living skills at an age-appropriate level; or
- d) Substantial need for supports to augment or replace insufficient or unavailable natural resources;

AND

2. Diagnosis:

Individual meets the following diagnostic criteria as determined by a professional licensed to make such determination:

- a) Adults with mental illness, excluding personality disorders and V-Codes;
or
- b) Children and adolescents with serious emotional disturbance, including those displaying signs of such disorders; or
- c) Persons with a developmental disability including mental retardation and other neurologically disabling conditions, epilepsy, cerebral palsy, and autism, which require treatment similar to that for individuals with mental retardation; or
- d) Children and adolescents with dependence on alcohol or other drugs, and those displaying signs of such disorders; or
- e) Adults with dependence on alcohol or other drugs; or
- f) Persons with autism and other developmental disabilities who do not meet the criteria under C are eligible for family support services, only.

Each region will have an array of services available through a variety of contracted providers. Determination of service needed is based on individual assessment. When determining the services needed for individuals who abuse substances or who is addicted to substances, the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd edition (ASAM) placement criteria are to be used. Providers must keep a record of the number of consumers served under each ASAM Level of service they provide. The table on the next page gives you a crosswalk between the service definitions and the ASAM levels of service. In addition to using the ASAM placement criteria, providers should use a uniform assessment tool such as the Addiction Severity Index (ASI).

SERVICES	ASAM / DESCRIPTION
Outreach	May be a component of any level of service
Early Intervention	Level 0.5
Diagnostic / Functional Assessment	All levels of service. Assessment of the consumer conforming to the six dimensions of the ASAM PPC-2
Crisis Intervention	May be a component of any level of service
Crisis Stabilization Program	Levels III 2-D; III.7, III.7-D
Residential Detoxification	Levels III.2-D; III.7-D
Community Based Inpatient Services	Level III.7
Community Based Inpatient Detoxification	Level III.7-D
Pharmacy Services	All levels of service
Consumer/Family Assistance	All levels of service
Respite	All levels of service
Physician Assessment and Care	May be a component of any level of service
Nursing Assessment and Health Services	May be a component of any level of service
Medication Administration	May be a component of any level of service
Ambulatory Detoxification	Level I-D
Opioid Maintenance Therapy	Level OMT
Assertive Community Treatment (ACT)	Levels I, II.1, II.5, III.1, III.3, III.5
Individual Counseling	May be a component of any level of service
Group Training / Counseling	May be a component of any level of service
Family Training / Counseling	May be a component of any level of service
Intensive Family Intervention	Adolescent Level I, II.1, II.5
Community Support – Team	Level I, II.1, II.5, III.1, III.3
Community Support – Individual	Level I, II.1, II.5, III.1, III.3
Individual Supported Employment	Level I, II.1, II.5, III.1, III.3
Group Supported Employment – Mobile Crews	Level I, II.1, II.5, III.1, III.3
Day Supports for Children and Adolescents	Adolescent Level I
Day Treatment for Children and Adolescents	Adolescent Level II
Day Habilitation	Not Applicable
Peer Support	Level I
Substance Abuse Day Services	Levels II.1, II.5
Substance Abuse Adolescent Day Treatment	Adolescent Levels I, II
Activity Therapy	May be a component of any level of service
Intensive Day Treatment (Partial Hospitalization)	II.5
Independent Living Supports	Level III.1
Skills Training and Supported Living	Level III.3
Structured Living Supports	Level III.5
Intensive Living Supports	Level III.7
Service Entry and Linkage	May be a component of any level of service

**DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES**

**CORE REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS
Operated by COMMUNITY SERVICE BOARDS**

EFFECTIVE JULY 1, 2001

Crisis Stabilization Program standards for adults are incorporated by reference into those found in the State of Georgia Department of Human Resources Division of Mental Health, Mental Retardation & Substance Abuse document entitled “Core Requirements for All Providers”, more specifically the section entitled “Specific Services and Supports”.

The FY06 CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified and may be modified only pursuant to agreement between DHR and DCH.

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). The Crisis Stabilization Program is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric stabilization and detoxification services. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate [as emergency receiving, evaluating and treatment facilities] any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Division of MHDDAD state hospital facility]⁴ for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable standards in the “Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services” [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

Interpretive guideline 3: Crisis stabilization programs are state supported residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric stabilization and detoxification services on a short term basis.

⁴ CSP’s may be state operated effective FY04

Interpretive guideline 4: The target population served in the CSP is adults (age 18 or older) with severe and persistent mental illness, persons with substance related disorders and persons with co-occurring mental health and substance use needs.

Interpretive guideline 5: Emancipated minors and juveniles who are age 17 may be served within these programs when their need for stabilization can be met by the CSP, when they do not need specialized child and adolescent services, and when their life circumstances demonstrate they are more appropriately served in an adult environment. Such admissions must be approved by the Medical Director.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the *American Society for Addiction Medicine Patient Placement Criteria* (ASAM), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Georgia Department of Human Resources Office of Regulatory Services under the “Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs”. These CSP standards shall not apply.

Interpretive guideline 8: Psychiatric stabilization services offered within the CSP **shall not exceed** services described in Level Six of the *Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2000* (LOCUS), published by the American Association of Community Psychiatrists, May 30, 2000.

Interpretive guideline 9²: The term “emergency receiving facility” means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHM RSA ERETF 290-4-1-.01(d).

Interpretive guideline 10²: The term “evaluating facility” means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHM RSA ERETF 290-4-1-.01(e).

Interpretive guideline 11²: Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 “Physical Plant and Safety” and section .12 “Food Service”.

Interpretive guideline 12⁶: CSP’s that are newly constructed or CSP’s undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- a. Shower fixtures in bathrooms shall be flush-mounted in the wall
- b. Headers supporting bathroom stalls shall be flush-mounted to the ceiling
- c. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a window in the door to the room
- d. Blind spots on the unit and in the seclusion and restraint room shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets

² Added to CSP Standards FY02

⁶ Added to CSP Standards FY06

- e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
- f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary clients.

Interpretive guideline 1^{6.1}: The program description of the CSP clearly describes their service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETf 290-4-1-.01(f).

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility or service.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient service.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings them within the purview of Georgia’s Certificate of Need (CON) Program as defined by the CON Statue and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service which brings them within the purview of Georgia’s Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program which comprehensive program has been certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for

^{6.1} Modified FY06

² Added to CSP Standards FY02

Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*], and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

SSr 11.3. LINKAGES FOR CARE OF COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

The purpose of clinical services provided by the CSP are psychiatric stabilization or detoxification. When it becomes evident 48 hours into the ‘evaluation’ legal status that a client is not stabilizing and may not stabilize quickly, arrangements shall be made to transfer the client to a designated treatment facility at that point. The transfer of the client shall take place no later than 72 hours into the ‘evaluation’ legal status, unless there has been a different time limit established in a written agreement with a hospital. The client may be transferred to the treatment facility on the existing 1014 or 2014 legal status. For the purposes of calculating the 48 or 72 hours, Saturdays, Sundays or holidays will not apply.

Interpretive guideline 3: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of clients.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP’s will operate within the guidelines of EMTALA with respect to the stabilization and transfer of clients to and from hospitals.

⁶ Added to CSP Standards FY06

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2.1}. The average annual length of stay shall not exceed five (5) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual person may not remain in a CSP beyond 10 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4.1}: A CSP must designate transitional beds separate from crisis residential beds. Clients occupying transitional beds may remain in the CSP beyond 10 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the individual is actively engaged in transitioning to the community^{6.1}**. The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a) A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b) A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c) A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Division of MHDDAD for both regular and transitional CSP beds.

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2.1} The primary revenue source shall be public funds.

Interpretive guideline 1: Review of fund sources for the CSP will show that no less than 95% of the funding is public, including government payers.

SSr 11.7(b). Clients are billed on a sliding fee scale basis according to their ability to pay.

Interpretive guideline 1: Review of billing practices shall demonstrate that clients have been billed on a sliding fee scale basis.

^{2.1} Modified FY02

^{4.1} Modified FY04

^{6.1} Modified FY06

⁴ Added to CSP Standards FY04

² Added to CSP Standards FY02

^{2.1} Modified FY02

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: “Physician” means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

SSr 11.8(b) A physician shall conduct assessments of new clients, address client care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP at the request of the charge nurse.

Interpretive guideline 2: CSP’s must have capacity to admit and discharge seven days a week.

Interpretive guideline 3: A physician must assess each new client within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum the initial evaluation of the client, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the client at the time of discharge.

SSr 11.8(c). The functions performed by physician’s assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician’s assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and procedures required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the program whose job responsibilities include, but are not limited to, clinical supervision of nursing staff and the implementation of physician’s orders.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

SSr 11.10. STAFF TO CLIENT RATIOS

SSr 11.10. Staff to client ratios shall be established based on the stabilization needs of clients being served.

Interpretive guideline 1: The ratio of direct care staff to clients should not be less than 1:8 (including the Registered Charge Nurse).

Interpretive guideline 2: There shall always be at least two staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11. USE OF SECLUSION OR RESTRAINT

SSr 11.11(a). A Crisis Stabilization Program may only use restraint and seclusion as a safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: All physical restraints and seclusion shall be used solely for the purposes of providing effective treatment and protecting the safety of the patient and other persons and shall not be used as punishment [or] for the convenience of staff. Physical restraints and seclusion should only be used when no less restrictive methods of controlling behavior which would reasonably insure the safety of the patient and other persons are feasible. Rules of DHR MHMRSA PR290-4-6-.02 (1)(c)1.

Interpretive guideline 3^{5.1}: Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 4^{5.1}: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of

^{5.1} Modified FY05

^{5.1} Modified FY05

seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with clients.

Interpretive guideline 5: The body of the admission assessment shall contain an assessment of past trauma or abuse. The person shall also be asked how they would prefer to be approached should they become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

SSr 11.11(b).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode within one hour of the implementation of seclusion or restraint intervention.

Interpretive guideline 1^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. An order must be given that approves the use of the seclusion or restraint intervention, that defines specific time limits for the episode (not to exceed four (4) hours), and that states the behavioral indicators which signal the end of the episode. The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 2⁵: The treating physician must be consulted as soon as possible if the restraint or seclusion is ordered by a licensed practitioner permitted by the State who is not a physician.

SSr 11.11(c).^{5.1} A physician or other licensed practitioner permitted by the State must personally examine the client if the episode exceeds one hour of the beginning of the seclusion or restraint episode or within the time frame that is consistent with federal regulations.

Interpretive guideline 1^{5.1}: The physician or CNS must personally examine the client by the end of the first hour of the seclusion or restraint episode or within the time frame consistent with current federal regulations. The findings of the examination of the client shall be documented in the client record.

Interpretive guideline 2: If the client is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or CNS, the rationale for release of the client *and* the fact that the client was not personally seen by a physician or CNS shall be fully documented within the client record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made **ONLY** after the client is **PERSONALLY** examined by a physician or CNS and may be ordered for an additional specific time episode not to exceed four (4) hours.

Interpretive guideline 4: After any seclusion or restraint episode, there must be a determination by the treating physician or Medical Director as to whether transfer to a treatment facility is indicated. The treating physician or Medical Director's determination must be documented within the progress notes. Justification for maintaining the client at the CSP for additional care must be contained in the physician progress note.

⁵ Added to CSP Standards FY05

^{5.1} Modified FY05

SSr 11.11(d). During the seclusion or restraint episode, the person must be continuously monitored and a documentation entry to that effect be made every 15 minutes.

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door when a client is secluded.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a client is restrained.

Interpretive guideline 3: A patient placed in physical restraints shall be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each person should be spoken to, checked for indications of obvious physical distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A person in restraints should receive all meals available to other patients except as otherwise ordered by a physician based upon the person's health needs and as his condition to take meals while in restraints. In all situations, the client must receive nutrition at regular meal intervals unless refused by the client. Restraints are to be discontinued when they are no longer needed to prevent a person from hurting himself or others and his medical needs allow removal.

SSr 11.11(e). Staff shall conduct a debriefing with the client after release from seclusion or restraint.

Interpretive guideline 1: The client shall have an opportunity to talk to an appropriate staff member authorized by the facility (preferably a staff member who was not involved in the incident), as soon as appropriate after release from seclusion or restraint.

Interpretive guideline 2: The following are potential issues to explore with the client:

- What the client remembers happening prior to their becoming angry, destructive or self injurious?
- Whether the client remembers sensory changes prior to being placed in seclusion or restraints?
- What thoughts the client has about why the client was placed in seclusion or restraint?
- How the client felt while in seclusion or restraint?
- How the client felt after being released from seclusion or restraint?
- Was there something the client did that was helpful in gaining personal control?
- Was there something the staff did that was helpful in the client gaining personal control?
- What changes could be made to assist the client in future instances when the client might lose control?

Interpretive guideline 3: The client responses shall be documented with pertinent intervention information incorporated within the client plan of care.

SSr 11.11(f). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: The staff members involved in the seclusion or restraint episode shall be interviewed immediately after the episode to determine the following information. The identified leader of the episode shall conduct the critique of the seclusion or restraint episode.

- What physical cues were present that indicated escalation of client behaviors?
- What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
- What was the client response to each intervention conducted?
- Could alternate interventions resulted in a different outcome other than seclusion or restraint?
- What did the staff involved do well?
- What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- What recommendations shall be documented within the client plan of care for use in future situations?

SSr 11.12 ORGANIZATIONAL RISK AND COMPLIANCE⁶

SSr 11.12 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

SSr 11.13 PHARMACY SERVICES

SSr 11.13 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a 'retail' or 'hospital' license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

⁶ Added to CSP Standards FY06

SSr 11.14. MEDICATION ADMINISTRATION

SSr 11.14 in all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Clients' Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the client and other persons and shall not be used as punishment or for the convenience of staff.

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent for Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.⁶

SSr 11.15. PROVISION OF INDIVIDUALIZED CARE

SSr 11.15. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each client including co-occurring mental health and substance use needs.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the person in psychiatric distress and to the person requiring detox from substances.

Interpretive guideline 2: The client clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 3: Staff training records shall show evidence of annual training and competency in caring for the person with co-occurring mental health and substance use issues.

SSr.11.16 REPORTING OF SERIOUS OCCURRENCES⁶

SSr.11.16. The CSP must report each serious occurrence.

Interpretive guideline 1: Serious occurrences shall be reported as specified in Policy 2:101 of the Division of MHDDAD, *Reporting and Investigating Consumer Deaths and other Serious Incidents*.

SSr. 11.16 DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.16. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the department. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location

⁶ Added to CSP Standards FY06

⁶ Added to CSP Standards FY06

- Program closure
- DHR finding of failure to comply with CSP standards
- Loss of accreditation

**DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES**

**CORE REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS
FOR CHILDREN AND YOUTH**

EFFECTIVE JULY 1, 2005

The following requirements for Crisis Stabilization Programs for Children and Youth have been built from the Core Requirements for Crisis Stabilization Programs serving adults that were implemented in July of 2000, and have been modified to address issues around children and youth.

The FY06 CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the “Letter of Agreement” between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified.

Crisis Stabilization Program standards for children and youth are incorporated by reference into those found in the State of Georgia Department of Hyman Resources Division of Mental Health, Mental Retardation & Substance Abuse document entitled “Core Requirements for All Providers”, more specifically the section entitled “Specific Services and Supports”.

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). The Crisis Stabilization Program for children and youth is a medically monitored short-term residential service operated by the Community Service Board⁴ for the purpose of providing psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate [as emergency receiving, evaluating and treatment facilities] any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term “Crisis Stabilization Program (“CSP”) means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program [operated by a Community Service Board or by a Division of MHDDAD state hospital facility]⁴ for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable standards in the “Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services” [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

⁴ CSP’s may be state operated effective FY04

Interpretive guideline 3: Crisis stabilization programs are state authorized residential services provided as a part of a Community Service Board⁴ and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric or behavioral stabilization and detoxification services on a short term basis. CSP's for children and youth are not designed to provide 'study and report' services or to be available for court ordered placement for the purpose of temporary placement only.

Interpretive guideline 4: The target population served in the CSP is children and youth ages 5-17 requiring psychiatric or behavioral stabilization and youth ages 13-17 with substance related disorders or with co-occurring mental health and substance use needs.

Interpretive guideline 5: Youth through age 21 may be served at a Crisis Stabilization Program for Children and Youth *provided* it is indicated clinically and is based on the youth's maturational age. The Medical Director must approve such admissions.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the Adolescent Criteria section of the *American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2R), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Georgia Department of Human Resources Office of Regulatory Services under the "Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs". These CSP standards shall not apply.

Interpretive guideline 8: Psychiatric stabilization services offered within the CSP **shall not exceed** services described in Level Six of the *Child and Adolescent Level of Care Utilization System for Psychiatric and Addiction Services*, Version 1.5 (CALOCUS), published by the American Association of Community Psychiatrists.

Interpretive guideline 9²: The term "emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(d).

Interpretive guideline 10²: The term "evaluating facility" means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

Interpretive guideline 11²: Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 "Physical Plant and Safety" and section .12 "Food Service".

Interpretive guideline 12⁶: CSP's that are newly constructed or CSP's undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

- b. Shower fixtures in bathrooms shall be flush-mounted in the wall
- c. Headers supporting bathroom stalls shall be flush-mounted to the ceiling

⁴ CSP's may be state operated effective FY04

² Added to CSP Standards FY02

⁶ Added to CSP Standards FY06

- d. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a window in the door to the room. Blind spots on the unit shall be addressed through use of convex mirrors allowing for visual access. A room used for seclusion or restraint must:
 - i. Allow staff full view of the resident in all areas of the room;
 - ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
- e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
- f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary residents.

Interpretive guideline 1^{6.1}: The program description of the CSP clearly describes its service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term ‘treatment facility’ means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETf 290-4-1-.01(f).

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility as provided in Part 3 of Article 3 of Chapter 3 of Title 37.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word “inpatient” anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient services.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).² The CSP shall not operate in a manner or offer any service that brings it within the purview of Georgia’s Certificate of Need (CON) Program as defined by the CON Statute and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service that brings them within the purview of Georgia’s Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

^{6.1} Modified FY06

² Added to CSP Standards FY02

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program which comprehensive program has been certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*], and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETf 290-4-1-.02(d).

Interpretive guideline 2⁶: Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD “Core Requirements for All Providers” contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

SSr 11.3. LINKAGES FOR COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

“The purpose of clinical services provided by the CSP are psychiatric or behavioral stabilization for children and youth who are severely emotionally disturbed and detoxification for youth ages 13-17 with substance related disorders or co-occurring mental health and substance use needs.”

Interpretive guideline 3: The CSP shall have an agreement that makes available medical pediatric services for children and youth.

Interpretive guideline 4: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETf 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

⁶ Added to CSP Standards FY06

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of residents.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP's will operate within the guidelines of EMTALA with respect to the stabilization and transfer of residents to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5^{2,1}. The average annual length of stay shall not exceed nine (9) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual child or youth may not remain in a CSP beyond 14 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2^{4,1}: A CSP must designate transitional beds separate from crisis residential beds. Residents occupying transitional beds may remain in the CSP beyond 14 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the resident is actively engaged in transitioning to the community.** The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

- a. A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
- b. A CSP with up to 39⁴ beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
- c. A CSP with 40⁴ or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 3: It is the intent of the Division of MHDDAD that children or youth shall return to their natural environment as quickly as possible. Therefore the TOTAL LENGTH OF STAY in a CSP for any one episode of care that includes a stay in both a crisis residential bed and a transitional bed **shall not exceed 29 calendar days.**

Interpretive guideline 4²: CSP's shall report census and length of stay data as required to the Division of MHDDAD for both regular and transitional CSP beds.

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).^{2,1} The primary revenue source shall be public funds.

^{2,1} Modified FY02

^{4,1} Modified FY04

⁴ Added to CSP Standards FY04

² Added to CSP Standards FY02

^{2,1} Modified FY02

Interpretive guideline 1: Review of fund sources for the CSP will show that no less than 95% of the funding is public, including government payers.

SSr 11.7(b). Legal guardians are billed on a sliding fee scale basis according to their ability to pay. Fees for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice shall be set by mutual agreement by the Departments.

Interpretive guideline 1: Review of billing practices shall demonstrate that residents' legal guardians have been billed on a sliding fee scale basis.

Interpretive guideline 2: Review of billing practices shall demonstrate that fees billed for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice are billed according to agreements set by the Departments.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: "Physician" means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: It is preferred that the CSP is under the direction of a psychiatrist with training or experience in working with children and youth.

Interpretive guideline 4: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

SSr 11.8(b) A physician shall conduct assessments of new residents, address resident care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP at the request of the charge nurse.

Interpretive guideline 2: CSP's must have capacity to admit and discharge seven days a week, 24 hours per day.

Interpretive guideline 3: A physician must assess each new resident within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum, the initial evaluation of the resident, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the resident at the time of discharge.

SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and procedures required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the program whose job responsibilities include, but are not limited to, clinical supervision of nursing staff and the implementation of physician's orders.

Interpretive guideline 2: It is preferred that the designated Registered Nurse administrator has training or experience with children and youth.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

SSr 11.10. STAFF TO RESIDENT RATIOS

SSr 11.10. Staff to resident ratios shall be established based on the stabilization needs of residents being served.

Interpretive guideline 1: The ratio of direct care staff to residents should not be less than one to four (1:4), including the Registered Charge Nurse.

Interpretive guideline 2: There shall always be at least three staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11 USE OF TIME OUT

SSr 11.11(a) If "time out" or "time away" is used as a less restrictive intervention prior to using an emergency safety intervention, the "time out" or "time away" shall be used according to these guidelines.

Interpretive guideline 1: Time out may be utilized in these ways:

- a. Away from the area of activity or from other residents, such as in the resident's room (exclusionary)
- b. In the area of activity or other residents (inclusionary)

Interpretive guideline 2: A resident in time out must never be physically prevented from leaving the time out area.

Interpretive guideline 3: The seclusion or restraint room shall not be used for time out

Interpretive guideline 4: Staff must monitor the resident while he or she is in time out.

SSr 11.12. USE OF SECLUSION OR RESTRAINT

SSr 11.12(a). A Crisis Stabilization Program for children and youth may only use restraint and seclusion as an emergency safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.

Interpretive guideline 3: Restraint and seclusion may not be used simultaneously.

Interpretive guideline 4: All physical restraints and seclusion shall be used solely for the purposes of providing an immediate response to an emergency safety situation

- a. Restraint or seclusion must not result in harm or injury to the resident.
- b. Restraint or seclusion must be used only to ensure the safety of the resident or others during an emergency safety situation.
- c. Restraint or seclusion must be used only until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
- d. Restraint or seclusion shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 5: Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective.

Interpretive guideline 6: All documentation related to the safety intervention of last resort must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

- a. Each order for restraint or seclusion.
- b. The time the emergency safety intervention actually began and ended..
- c. The time and results of the 1-hour assessment conducted by the physician or clinically qualified registered nurse.

- d. The emergency safety situation that required the resident to be restrained or put in seclusion.
 - a. The names of staff involved in the emergency safety intervention.
 - b. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 7: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with residents.

Policy, procedures and training documentation evidence must include:

- a. Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations.
- b. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
- c. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or who are in seclusion.
- d. Evidence of exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
- e. Evidence that staff are trained and demonstrate competency before participating in an emergency safety intervention.
- f. Evidence that staff have demonstrated their competencies related to seclusion and restraint on a semiannual basis.
- g. Evidence of current certification in the use of cardiopulmonary resuscitation.
- h. Evidence that staff have demonstrated their competency in cardiopulmonary resuscitation on an annual basis.

Interpretive guideline 8: The CSP must document in the staff personnel records that the training and demonstration of competency were successfully completed.

- a. Documentation must include the date training was completed and the name of persons certifying the completion of training

SSr11.12.(b). Notification of the CSP policy on seclusion or restraint must be given.

Interpretive guideline 1: The CSP must inform both the incoming resident and the resident's parent(s) or legal guardian(s) of the CSP's policy regarding the use of restraint or seclusion during an emergency safety situation of last resort.

Interpretive guideline 2: The CSP must communicate its restraint and seclusion policy in a language that the resident or his or her parent(s) or legal guardian(s) understands (including American Sign Language) and when necessary, the CSP must provide interpreters or translators.

Interpretive guideline 3: The CSP must obtain an acknowledgment, in writing, from the resident, the parent(s) or legal guardian(s) that he or she has been informed of the CSP's policy on the use of restraint or seclusion during an emergency safety situation. This acknowledgment must be filed in the resident's record.

Interpretive guideline 4: The CSP must provide a copy of the facility policy to the resident and to the resident's parent(s) or legal guardian(s).

Interpretive guideline 5: The CSP's policy must provide contact information, including the phone number and mailing address, for the State Protection and Advocacy organization.

SSr.11.12(c). Each resident shall be assessed for a history of past trauma or abuse.

Interpretive guideline 1: The body of the admission assessment shall contain an assessment of past trauma or abuse. The resident and his or her parent or legal guardian shall also be asked how he or she would prefer to be approached should he or she become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

Interpretive guideline 2: Emergency safety interventions must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse).

SSr 11.12(d).^{5.1} A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode as soon as possible within the first fifteen minutes of the implementation of seclusion or restraint intervention.

Interpretive guideline 1: Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and CSP.

Interpretive guideline 2^{5.1}: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. The physician or CNS must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

Interpretive guideline 3: If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other staff licensed to receive orders, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

- a. If the treating physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained.
- b. The physician ordering the restraint or seclusion must verify the verbal order in a signed written form in the resident's record as soon as possible.
 - i. If the physician or CNS giving the order is not the resident's treating physician, the physician or CNS must consult with the treating physician as soon as possible and inform the treating physician of the emergency safety situation;
 - ii. Staff must document in the resident's record the date and time the treating physician was consulted.

Interpretive guideline 4: Each order for restraint or seclusion must:

- a. Be limited to no longer than the duration of the emergency safety situation.
- b. Specify the time limits for the restraint or seclusion episode. Under no circumstances shall an order exceed :
 - i. Four (4) hours for residents ages 17 and above;
 - ii. Two (2) hours for residents ages 9 to 17;
 - iii. One (1) hour for residents under age 9.
- c. Specify the behavioral indicators that signal the end of the episode.

^{5.1} Modified FY05

^{5.1} Modified FY05

- d. State that the restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 4: If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint or seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

Interpretive guideline 5: Each order for restraint or seclusion must include:

- a. The name of the ordering physician or CNS;
- b. The date and time the order was obtained;
- c. The emergency safety intervention ordered;
- d. The length of time for which the physician authorized its use;
- e. The behavioral indicators that signal the end of the episode.

The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 6: Orders for restraint or seclusion may not be written as a standing order or as an as-needed basis.

SSr 11.12(e).^{6.1} A physician or clinically qualified registered nurse must personally examine the resident within one (1) hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode.

Interpretive guideline 1^{5.1}: The physician or clinically qualified registered nurse must personally examine the resident within one hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode. The findings of the examination of the resident shall be documented in the resident record and must include the resident's physical and psychological well being, including but not limited to:

- a. The resident's physical and psychological status.
- b. The resident's behavior.
- c. The appropriateness of the intervention measures.
- d. Any complications resulting from the intervention.

Interpretive guideline 2: If the resident is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or clinically qualified registered nurse, the rationale for release of the resident *and* the fact that the resident was not personally seen by a physician shall be fully documented within the resident record.

Interpretive guideline 3^{5.1}: After the order expires, a new determination for continued seclusion or restraint may be made **ONLY** after the resident is **PERSONALLY** examined by a physician or a clinically qualified registered nurse and may be ordered by a physician or CNS for an additional specific time episode not to exceed:

- a. Four (4) hours for residents ages 17 and above;
- b. Two (2) hours for residents ages 9 to 17;
- c. One (1) hour for residents under age 9.

SSr 11.12(f). During the seclusion or restraint episode, clinical staff trained in the use of emergency safety interventions must be physically present, continuously monitoring the physical and psychological well-being of the resident and the safe use of restraint or seclusion, and shall document findings and care given every 15 minutes.

^{6.1} Modified FY06

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door and must continuously visually monitoring the resident when seclusion is utilized.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a resident is restrained.

Interpretive guideline 3: A resident placed in physical restraints must be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each person should be spoken to, checked for indications of obvious physical and psychological distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A person in restraints should receive all meals available to other patients except as otherwise ordered by a physician based upon the person's health needs and as his condition to take meals while in restraints. In all situations, the resident must receive nutrition at regular meal intervals unless refused by the resident. Restraints are to be discontinued when they are no longer needed to prevent a person from hurting himself or others and his medical needs allow removal.

Interpretive guideline 5: Video monitoring does not meet the requirement of personal monitoring of the resident while in seclusion or restraints.

Interpretive guideline 6: The physician must be available to staff for consultation at least by telephone throughout the period of the emergency safety intervention.

SS 11.12(g). Notification of the use of seclusion or restraint shall be given to the parent(s) or legal guardian(s).

Interpretive guideline 1: The CSP must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

Interpretive guideline 2: The CSP must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention including the date and time of notification and the name of the staff person providing the notification.

SSr 11.12(h). Staff shall conduct a debriefing with the resident within 24 hours after release from seclusion or restraint.

Interpretive guideline 1: The resident shall have an opportunity to talk to staff members within 24 hours after release from seclusion or restraint. This discussion must include staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident. The discussion may include supervisory and administrative staff if appropriate.

Interpretive guideline 2: The following are potential issues to explore with the resident:

- a. Circumstances resulting in the use of seclusion or restraint, including:
 - i. What the resident remembers happening prior to becoming angry, destructive or self injurious.
 - ii. Whether the resident remembers sensory changes prior to being placed in seclusion or restraints.

- iii. What thoughts the resident has about why the resident was placed in seclusion or restraint.
- iv. How the resident felt while in seclusion or restraint.
- v. How the resident felt after being released from seclusion or restraint.
- b. The outcome of the interventions used, including any injuries that may have resulted from the use of seclusion or restraint.
- c. Strategies to be used by the staff, the resident or others that could prevent the future use of restraint and seclusion.
- a. Alternative techniques might have prevented the use of seclusion or restraint.
- d. Procedures, if any, that staff should implement to prevent any recurrence of the use of restraint or seclusion.
- e. Strategies that were helpful to the resident in gaining personal control:
 - i. Was there something the resident did that was helpful in gaining personal control?
 - ii. Was there something the staff did that was helpful in the resident gaining personal control?

Interpretive guideline 3: Staff must document in the resident's record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing.
- b. The names of staff who were excused from the debriefing.
- c. Any changes to the resident's treatment plan that results from the debriefing.

SSr 11.12(i). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff must conduct a debriefing session that includes, at a minimum, a review and discussion of:

- a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention, such as:
 - i. What physical cues were present that indicated escalation of resident behaviors?
- b. Review of techniques used and alternative techniques that might have prevented the use of the restraint or seclusion:
 - i. What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
 - ii. What was the resident response to each intervention conducted?
 - iii. Could alternate interventions resulted in a different outcome other than seclusion or restraint?
- c. What did the staff involved do well?
- d. What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
- e. What recommendations shall be documented within the resident plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the resident's record that debriefing took place and must include:

- a. The names of staff who were present for the debriefing;
- b. The names of staff who were excused from the debriefing;
- c. Any changes to the resident's treatment plan that results from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that results

in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.13 MEDICAL TREATMENT FOR INJURIES RESULTING FROM A SAFETY INTERVENTION

SSr 11.13 The CSP shall insure that medical treatment is immediately obtained from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 1: Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 2: Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff from that intervention.

SSr 11.14 ORGANIZATIONAL RISK AND COMPLIANCE

SSr 11.14 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline 1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

Interpretive guideline 4: Each CSP with a current Medicaid provider agreement must provide to the State Medicaid agency, at the time it executes a provider agreement with the Medicaid agency, in writing, that the CSP is in compliance with CMS's standards governing the use of restraint and seclusion. The CSP director must sign this attestation.

SSr 11.15 PHARMACY SERVICES

SSr 11.15 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a 'retail' or 'hospital' license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

SSr 11.16. MEDICATION ADMINISTRATION

SSr 11.16 In all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Residents' Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the resident and other persons and shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 2⁶: The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent for Psychotropic Medication*, concerning the use of psychotropic medications and the use of involuntary medications.⁶

SSr 11.17 INDIVIDUALIZED CARE

SSr 11.17. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each resident including psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. Educational and program offerings shall also include attention to the child or youth's academic development.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the child or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

Interpretive guideline 2: Each child or adolescent shall be assessed to determine his or her academic development. The CSP shall utilize educational integration services has a mechanism to support and enhance the child or adolescent's academic development.

- a. Educational specialists or teachers will be available to provide instruction and support services such as tutoring;
- b. Individualized planning and linkage shall occur with child or youth's community school.

Interpretive guideline 3: Educational, program and academic offerings are age appropriate and presented in a way easily understood by the resident.

Interpretive guideline 4: The resident's clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 5: A record of academic assessment, offerings and the child or youth's response to those offerings shall be maintained in a separate record that shall be filed with the clinical record at discharge.

Interpretive guideline 6: Staff training records shall show evidence of annual training and competency in caring for children or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

SSr.11.18 REPORTING OF SERIOUS OCCURRENCES

SSr.11.18. The CSP must report each serious occurrence.

⁶ Added FY06

Interpretive guideline 1: Serious occurrences shall be reported as specified in Policy 2:101 of the Division of MHDDAD, *Reporting and Investigating Consumer Deaths and other Serious Incidents*.

Interpretive guideline 2: The CSP must report any serious occurrence to both the State Medicaid agency and, unless prohibited by law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include:

- a. Resident's death
- b. Resident's suicide attempt
- c. Serious injury to a resident manifesting itself as any serious impairment of the physical condition of the resident as determined by qualified medical personnel including, but not limited to:
 - i. Burns
 - ii. Lacerations
 - iii. Bone fractures
 - iv. Substantial hematoma
 - v. Injuries to internal organs, whether self-inflicted or by someone else

Interpretive guideline 3: The CSP shall notify the resident's parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after a serious occurrence.

Interpretive guideline 4: A description of the serious occurrence must be recorded in the resident's record, including:

- a. Medical treatment sought, outcome of treatment, and follow-up required;
- b. That the serious occurrence was reported, including
 - i. The names of the parent(s) legal guardian(s) to whom it was reported
 - ii. The name of the agencies to which it was reported, including the name of the person at the agency who received the report.
 1. The State Medicaid Agency (if the CSP is enrolled as a Medicaid provider)
 2. The State Protection and Advocacy system
 3. The Division of MHDDAD

Interpretive guideline 5: In addition to the agencies listed above, if the CSP is enrolled as a Medicaid provider, ALL DEATHS of any resident must be reported to the Regional Office for the Centers for Medicare and Medicaid (CMS) by no later than the close of the next business day after the resident's death.

- a. The method of reporting and corresponding documentation noted within this standard shall apply.
- b. Staff must document in the resident's record that the death was reported to the CMS regional office.

Interpretive guideline 6: A copy of the incident and accident report shall be kept by the CSP.

SSr. 11.19 DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.19. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the department. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- DHR finding of failure to comply with CSP standards
- Loss of accreditation

**OPERATING PROCEDURES
FOR RESPITE AND FAMILY SUPPORT SERVICES
{tc "GUIDELINES for FAMILY SUPPORT"}**

Purpose:{tc "Purpose" \ 2}

The purpose of these Operating Procedures is to establish the parameters within which Family Support programs under contract with DMHDDAD may provide and purchase Family Support services and goods. These Operating Procedures cover Family Support services provided under:

- Budget 400 for individuals with mental retardation, and
- Budget 440 for individuals with autism, and
- Budget 490 for individuals with other developmental disabilities.

Definition:

Family Support is actually an array of goods and services aimed at providing families with the very individualized support they need to continue to care for a family member with disabilities at home. Family Support is not generally seen as a crisis service. Rather, it is provided to families with the goal of preventing crises that can result in the need for out of home placements.

Eligibility

The family is eligible only if the member with disabilities is residing in the home, or if the Family Support funds are to be used to prepare the home and family for the return of the member with disabilities from an alternate care placement. Families will be determined eligible for services through a team process, utilizing the following criteria: 1) the individual with disabilities is three years or older with mental retardation, autism, or other developmental disabilities, and meets the Division's criteria for "Most in Need" (*Note: Children aged 0-3 years may be served if it is documented that Early Intervention funding has been exhausted.*); 2) the family wishes for the member to remain at (or return) home, but requires support and/or assistance in order for the individual to live in the home, and 3) the authorized goods and services are sufficient to support and/or assist the continuance or return to home care.

Eligibility for services does not equate to an entitlement to services. Prioritizing eligible families to receive services will be the responsibility of the staff or agency designated by the region, utilizing a team and family assessment process with consideration of (1) the criticalness of need to family functioning and well being, and (2) the family's financial ability to obtain services.

For the purposes of Family Support, "family" may be considered as the individual with disabilities living with his/her birth or adoptive parents, members of the extended family, a full guardian, legal custodian or a person acting in place of a parent or family member and living as a family unit. While families are the principal targets of Family Support, a family's eligibility for service is determined by the presence of an eligible member with disabilities.

Accessing Family Support Services:

The Regional MHDDAD Office is responsible for designating and publicizing one or more Family Support agencies to receive referrals from the Regional Intake and Assessment Agency. Each Contracted Agency will complete an application for family support services to gather pertinent information about the needs of the individual with the disability and his / her family. The contracted Family Support provider agency assesses a family's application based on: (1) consideration of the whole life needs of the disabled individual; (2) consideration of the needs of the family as primary caregiver; and (3) consideration of the community supports necessary to meet those needs.

The contracted agency must notify the family in writing of the approval or disapproval of their application for Family Support services within 30 days after receipt of the application. If the family is notified that they have been approved for admission into Family Support services, a meeting is scheduled for the purpose of developing an Individual Family Support Plan (in the case of a disapproval, see Provider Responsibilities, C. Grievances/Appeal Process).

Individual Family Support Plan (IFSP): All families/individuals receiving Family Support services must have an Individual Family Support Plan (IFSP). The region's designated Family Support provider agency is responsible for developing the IFSP through a group process that involves the family. The Individual Family Support Plan (IFSP) is a written participation agreement, signed by the individual and/or family, a representative of the contracted Family Support agency, and the designated Family Support Coordinator. The IFSP includes:

1. A description of the individual, the family and its support network, the physical environment, and current services;
2. A description of the needs of the individual and family, based on the assessment described above;
3. A listing of the specific goods/services (including a funding cap) that the family is authorized to receive through Family Support Funding. The types of goods and services that may be purchased with Family Support funding are detailed in the section, "Authorized Goods and Services."
4. Documentation that the authorized goods and services are not available through other programs or sources.
5. A Family Support Agreement (Appendix 3).

Plan Review{tc "PLAN REVIEW" \1 2}

Individual Family Support Plans should be reviewed and updated at least once every six months. Documentation of family resources should occur on an annual basis. Plans should be reviewed and updated more often if family and consumer needs change, or in the event of a change in the family's resources. The family is responsible for informing the provider in the event of a change in the family's/individual's needs or of a change in the family's financial or other resources. The need for review or changes in the plan may be declared by the agency or by the family. Families should be informed in writing at the time of the initial assessment of the planned review cycle and of the family's right to participate and request changes, and of their duty to inform the Family Support Coordinator in the event of any significant changes in their needs or resources. If changes are made in the family's IFSP, the reason for the changes is included in the record. The individual and/or a family member, the Family Support Coordinator, and a representative of the contracted Family Support provider

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agency should sign the amended agreement. Amendments to the IFSP are not considered to be in effect until signed by the Contractor.

Authorized Goods and Services {tc "Authorized Goods and Services " \1 2}

The following is a listing of goods and services which may be purchased with Family Support funds. All goods and services purchased with Family Support funding must be provided in accordance with the Core Requirements for All Providers, in the Standards Section of the Provider Manual and these Operating Procedures for Family Support Services.

1. **Respite Care:** Services designed to relieve families/care givers of physical or emotional stresses associated with the care of the member with disabilities by the provision of temporary care of the member with disabilities; may be provided in or out of the home. Also may include care of other young children who are members of the family when necessary for the primary care giver(s) to devote exclusive time to attend to the care and well being of the member with disabilities.

Each Contracted Family Support Agency maintains a “List of Approved Respite Providers”. Prior to receiving any Family Support funding, respite care providers must be on a Contracted Family Support Agency’s “List of Approved Respite Providers”. For additional requirements regarding respite providers and this registry, see the Administration/Records section in these Family Support Operating Procedures.

2. **Personal Support:** An array of services to assist persons to perform activities of daily living. Personal Support includes the following:
 - a. Assistance with, and/or training in, activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring and other similar tasks;
 - b. Accompanying consumers and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities (This category includes staff to serve as interpreters and communicators and the transportation costs to provide the service.);
 - c. Training or assisting in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care and other similar tasks;
 - d. Assisting with therapeutic exercises, supervising self-administration of medication and performing other services essential to health care at home; and
 - e. Training and support in the areas of social, emotional, physical and special intellectual development. This category includes mobility training as well as programming, intervention and/or consultation to reduce inappropriate or maladaptive behaviors.
3. **Dental Services:** Any of the full array of services designed to care for the teeth, oral cavity and maxillo-facial area, provided by or under the direct supervision of a licensed dentist; in-patient or outpatient.

4. **Medical Care:** Services provided by or under the direct supervision of a licensed physician or by other licensed or certified health care professionals when recommended by a licensed physician. The array of Medical Care services are inclusive of diagnosis/evaluation, service provision and consultation with other medical/health care providers or non-medical service providers, provided by a licensed physician. Services may be inpatient or outpatient.
5. **Specialized Clothing:** Services which include the assessment of need, design, construction, fitting and cost of an article of clothing which is necessitated by the handicapping condition of the individual with disabilities.
6. **Specialized Diagnostic Services:** Specific investigative procedures determined needed by the family and inter-disciplinary team but not provided by the inter-disciplinary team that are necessary to complete the assessment of needs of the individual with disabilities and/or family.
7. **Recreation/Leisure Activities:** Activities and or goods designed to support the participation of the individual with disabilities in recreational/leisure activities in the home and/or community.
8. **Environmental Modifications:** Changes, additions or repairs to the personal home of the family/caregiver which are designed to increase their ability to enhance the development/functioning, health or well being of the individual with disabilities when such changes, additions or repairs are not structurally permanent.¹
9. **Specialized Equipment:** Adaptive and therapeutic devices specifically prescribed to meet habilitative needs of the individual with disabilities or devices and equipment needed by the family to better provide for the disability specific needs of the disabled member. (See Appendix "*FAMILY SUPPORT SERVICES SPECIALIZED EQUIPMENT DEFINITIONS*" {tc "Specialized Equipment Definitions" \l 2} for more detail regarding specialized equipment.)
10. **Therapeutic Services:** A direct intervention service provided by a specifically trained therapist aimed at reducing or eliminating physical manifestations of a disability or in improving/acquiring specific skills precluded by the disability; services proceed from assessment/evaluation to service provision. Therapeutic services are inclusive of audiology, physical therapy, occupational therapy and speech therapy.

¹ "The State is prohibited from expending funds for permanent modifications on real property to which it does not hold fee simple title because the State might lose the modifications if the owner appropriates the property to uses other than for which state funds were expended. In such case, the expenditure would result in a gift or gratuity prohibited by Georgia Constitution, Art.3, sec. 6 Op. ATT'Y Gen., 1972, p. 299". Excerpted from a memo by Division of Mental Health Mental Retardation and Substance Abuse Legal Officer, Sandy Laszlo, dated May 1, 1991.

- 11. Counseling:** Services utilizing a varied number of specific psycho-social approaches, clinical or non-clinical, family or individual, which are aimed at assisting individuals to cope with life circumstances.
- 12. Parent/Family Training:** Information and training for parents/family members to enhance understanding and to better address the family member's needs. Training may be one time or on-going and may be delivered in or out of the home.
- 13. Specialized Nutrition:** An array of services inclusive of assessment, planning, counseling, supervision and provision of specific dietary, nutritional and feeding needs of the individual with disabilities by a nutritionist qualified by state standards.
- 14. Supplies:** Any number of items which, while not specialized or specific to the needs of individuals with disabilities, may require frequent usage due to the disability or any number of items which, while not specialized, are necessary to the on-going operation or maintenance of specialized devices or any number of items which are needed by the family to better provide for the disability specific needs of the member with disabilities. The need for such supplies must be clearly documented in the IFSP.
- 15. Behavioral Consultation and Support:** Professional services which train and support the family in avoiding and/or responding appropriately to behaviors which may create barriers to the individual with disabilities remaining in the home and community; and/or direct consumer services intended to address problematic behaviors.
- 16. Financial and Life Planning Assistance:** Professional services which assistance the family in planning for the future service and/or financial needs of the family member with disabilities.
- 17. Exceptional Disability Related Living Costs**

This category could be used to pay living expenses that are higher than normal due to the nature of the person's disability or to cover unexpected emergency costs. For example, a person who is heat sensitive may require air conditioning during the summer months. The family support budget may include extra costs to cover the higher electrical bills during the summer months so as not to stress the family's household budget. This might also cover higher electrical bills caused by the individual with disabilities being on special monitoring machines. Exceptional Disability Related Living Costs may be approved on a one time, emergency basis, or for ongoing needs. When approved on an ongoing basis, the contracted Family Support Provider must document continued need at least every six months.
- 18. Homemaker Services** – Light household work or tasks provided in the home which are necessitated by the lack of a family member capable of performing such tasks or by the incapacity or absence of the family member who normally performs the tasks and which are not available through an existing program such as the Community Care Waiver.

19. **Transportation** – Travel and travel related costs (including subsistence costs) associated with the receipt of a plan service, and documented by the provider to be necessary to meet the needs of the family.
20. **Other Services:** Any other service not listed above, which, in the opinion of the family and inter-disciplinary team, is necessary to meet the needs of an eligible individual/family, when written request is made to and approval received from the DHR-DMHDDAD-Regional Coordinator. (See Appendix: *Family Support Waiver Request Form*.)

Provider Responsibilities{tc "PROVIDER RESPONSIBILITIES" \1 2}

A. Administration/Records

Eligible families will receive Family Support services within the limits of the funding available. The Contractor retains ultimate responsibility for appropriate administration and for all documentation. Family Support services have been defined broadly to allow as much flexibility, and thus, individualization as possible. A fundamental responsibility of the contracted Family Support provider agency is maintaining this programmatic flexibility while assuring appropriate fiscal controls. The Contractor is responsible for maintaining all records including (but not limited to) service vouchers/purchase orders, a registry of approved respite and service providers, receipts for services and all documentation of family and individual needs and resources. In addition to all applicable DHR Fiscal Policies, Family Support provider agencies must have documentation of the following:

- Funding of Last Resort: Family Support funding is “funding of last resort”. Documentation should cite efforts to secure goods and services through other sources such as Medicaid, local charitable organizations, or other generic resources. Family Support funds may be utilized in combination with other agency, community or individual family resources.
- Established Limits: Documentation including receipts of authorized and actual costs of family support services, both provided and purchased, will be maintained by the contracted Family Support provider, for each eligible person. **The Regional Coordinator must approve costs that exceed established limits in advance.** A request to exceed an established rate may be made on the *Family Support Waiver Request Form* in the Appendices to this section. Note: Families providing care for more than one member with disabilities may be eligible to receive the capped annual per family rate for each eligible person. Justification should be based on whether assessed need and planned-for services have a "shared" benefit to each member with disabilities. For example, such services as Counseling or Environmental Modifications may benefit members equally while the benefits of others, such as Supplies or Specialized Equipment, may not be easily shared.
- Fee for Services: Consistent with DMHDDAD contract requirements, all authorized Family Support goods and services shall be provided on a "sliding fee" basis. A Family Support Fee Policy, which includes a schedule of fees shall be established by the Provider Agency and approved by the Regional MHDDAD Office. Documentation of family income and resources will be obtained in order to determine if funds will be allocated. It is the responsibility of the contracted Family

Support provider agency to maintain documentation of adherence to the approved Fee Policy and compliance with all applicable DHR fiscal rules and regulations.

- **Payment Documentation:** The Contractor is responsible for maintaining all financial records. Families may be reimbursed for authorized Family Support expenditures, but funds are never “advanced”. Contractors are responsible for obtaining receipts and/or other appropriate documentation prior to dispersing Family Support funds.
- All documentation must be maintained in an easily accessible place for monitoring/auditing purposes.

B. Additional Requirements for Respite Services

- Each regional office maintains a list of **Contracted Family Support Agencies** with which the region contracts for the provision of respite. This list is available to anyone interested in it.
- Often times, Contracted Respite Agencies sub-contract with individuals who provide respite services. All Contracted Respite Agencies will have a Respite Provider application for individuals with whom they sub-contract that indicates the qualifications of the individual to provide respite services.
- It is the **Contracted Respite Agency’s** responsibility to ensure that only individuals who meet the specified requirements provide respite. Requirements include current CPR certification, a satisfactory criminal background check, and the training as specified in the Core Requirements Section III-B-11 under HR.11. The Contracted Agency will maintain documentation that all of these requirements are met. In addition, the Contracted Agency will maintain documentation of any specialized experience/training necessary to prepare the provider to meet the unique needs of individuals who receive respite services.
- The **Contracted Respite Agency** will maintain a **List of Individuals Approved to Provide Respite** that are either, employees or individuals with whom they sub-contract. Contracted Agencies will not add an individual to the list until they have documentation on hand that the individual meets all requirements to provide respite services.
- If a family desires for an individual who is not on the Region’s “List of Contracted Agencies” to provide respite, that individual must become a contracted provider of the Region or an employee or sub-contractor of one of the Region’s Contracted Respite Agencies prior to providing respite.
- **Public funds cannot be used to purchase or reimburse respite services provided by any person who is not included on the List of Individuals Approved to Provide Respite.**
- Each month the Region’s Contracted Respite Agencies will submit a Respite Report to the regional office along with the MIERS report. This Respite Report will document: 1) the persons served in respite during the report month, and 2) the

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individuals (employees of or individuals with whom the Contracted Respite Agency sub-contracts) who provided the respite services. A copy of the Respite Report is attached as Section III, Appendix 4.

C. Family Support Coordinator

Once families have been assessed, determined eligible and approved for Family Support services, a Family Support Coordinator will be available as a point of contact to assist families in identifying their unique support needs, define outcomes, and develop the IFSP. To the extent possible, and consistent with family wishes, the Family Support Coordinator will assist the individuals and their families to plan, organize and direct specific family support services as well as other services and supports not funded with Family Support dollars. The administrative and service coordinator duties may be split among more than one staff person.

D. Grievances/Appeal Process

Families denied, discontinued or whose benefits have been reduced must be notified in writing of the reasons for denial, discontinuation or reduction of benefits and must be informed in writing of their right to appeal these decisions. The Contractor established client appeal procedures should be consistent with the grievance procedures detailed in the Provider Manual.

E. Reporting

The Contractor will submit reports as required by the Regional MHDDAD Office.

F. Regional Office Responsibilities

The Region is responsible for reviewing documentation and assuring that the contracted providers are in compliance with the provision of these Operating Procedures. At a minimum, on a quarterly basis, regions should conduct a record review of 5% of the individuals served in Respite and Family Support services. Each sample must include some individuals who receive respite services. Regional Office staff will compare the information in the Respite Reports with the Contracted Agency's respite provider documentation to assure that all individuals providing respite are qualified.

REQUIREMENTS FOR PROVIDERS OF CHILD AND ADOLESCENT SERVICES TO INDIVIDUALS WITH SERIOUS EMOTIONAL DISTURBANCES

MATCH/LOC PLANNING

Providers of services to child and adolescents with serious emotional disturbances shall participate in MATCH/LOC planning activities, as appropriate. This would include:

- Attending and participating in monthly local MATCH/LOC committee meetings;
- Participating in utilization review and discharge planning for assigned children and adolescents in MATCH/LOC placements;
- Assisting in developing community placements/services for children and adolescents leaving MATCH/LOC placements.

STATE HOSPITAL LINKAGE AND COORDINATION

Providers of services to children and adolescents shall ensure linkage and coordination with state hospitals for children/adolescents referred to the state hospitals. This includes:

- Pre-screening of children and adolescents prior to referral to the state hospital;
- Regular contact with state hospital regarding individuals in the hospital;
- Joint discharge planning, particularly for youth in the JLJR class or youth found incompetent to stand trial, to ensure timely discharge from the hospital; and
- Linkage to needed community services upon discharge.

Provider shall use all available options to provide appropriate care and treatment in the community in lieu of hospitalization and/or out-of-home placements.

COLLABORATION WITH OTHER CHILD SERVING AGENCIES

Providers shall work closely with the Department of Juvenile Justice, the Division of Family and Childrens' Services, local schools, local juvenile court systems/judges and education departments and other child serving agencies to coordinate services and treatment. Mental health and addictive disease services shall be made available to children and adolescents served by other social service agencies who are in need of treatment.

MENTAL RETARDATION MEDICAID SERVICES

The expectations for Mental Retardation Medicaid Services listed below were formerly contained in an Annex of the MHDDAD Regional Master Contract.

I. CLIENTS RIGHTS/HEALTH AND SAFETY

The agency shall:

- A. Assure that consumers served are protected from abuse, neglect and exploitation.
- B. Submit all current and renewed licenses to the Regional Office. The agency will immediately notify the Regional Office of any deficiencies noted when its facilities and programs are reviewed or surveyed.
- C. Submit all accreditation/certification-related reports to the Regional Office.
- D. Have a system of contingency plans for emergencies; a copy of which will be submitted to the Regional Office.
- E. Participate in all meetings regarding consumer care and treatment as required.
- F. Comply with the Division's requirements in the management and protection of consumer funds.

II. REPORTING REQUIREMENTS

The agency shall participate in and report to the Mental Health/Mental Retardation Information System of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (the Division) and shall supply data requested by the Region, the Division or the Department for the analysis of service activities in the State. Data required may include, but are not limited to, outcomes, consumer preferences, CQI, grievances, incident reporting and detailed information about the service activities provided.

III. COMPLIANCE WITH LAWS AND REGULATIONS

The agency shall comply with all MR Waiver policies and procedures. This information can be accessed through the following web site:
www.communityhealth.state.ga.us (Click on Medicaid, click on Provider Manual).

IV. PROVIDER TRAINING

The agency shall:

- A. Develop staff training requirements that are appropriate and specific to the population(s) served.
- B. Assure and provide documented evidence of completion of provider training.
- C. Be trained in all aspects of the provision of waiver services and in all division requirements regarding the waiver.

PLANS OF CARE/ISP'S

The agency shall:

- A. Comply with the principle of allowing consumers to choose their providers and the type of services they receive based upon resource availability, sound clinical practice and fiscal accountability.
- B. Participate in ISP staffing and other related meetings required by the designated Service Coordinator/Monitor.
- C. Cooperate with the Service Coordinator/Service Monitor or Dedicated Case Manager. Assist the area Clinical Evaluation Team (CET) and staff of the Regional Office in services planning, continuous quality improvements, evaluation and monitoring.

VI. CONSUMER ELIGIBILITY REQUIREMENTS

The agency shall:

- A. Insure continued consumer eligibility for benefits for each consumer served such as Social Security benefits, Medicaid eligibility, etc. as appropriate to service provided.
- B. Secure and produce upon request all required Medicaid documents such as the Freedom of Choice forms, MOA communicators, DMA-80's, DMA-6, etc.
- C. Comply with DMA regulations regarding the MAO cost share/patient liability for consumers determined to be Medicaid eligible under the designation "Medical Assistance Only."

VII. FINANCIAL OVERSIGHT

The agency shall:

- A. Prepare an annual Medicaid Waiver Cost Accounting Report pursuant to procedures established by the Department of Human Resources and DMA.
- B. Be responsible for billing all parties liable for the services provided.
- C. Apply Supplemental Security Income benefits and any other income to the cost of basic room and board, personal allowance and other personal needs not specified in this agreement when the client(s) is provided Residential Training and Supervision or Personal Support.

VIII. QUALITY ASSURANCE PLANS

The agency shall:

- A. Demonstrate an adequate quality assurance system, which meets all the requirements of the "*Quality Assurance Plan for Medicaid Home and Community-Based Services Waiver Programs*" for assuring the health and welfare of waiver participants.
- B. Participate in the Division's Quality Assurance Plan for Home and Community-Based Services Waiver Programs, as outlined below.

IX. ALL OTHER REQUIREMENTS

The agency shall abide by all other requirements for MR waiver services promulgated by the Department of Community Health, Division of Medical Assistance and by the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases.